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No. 80-802

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

NATIONAL GERIMEDICAL HOSPITAL
AND GERONTOLOGY CENTER

Petitioner,

v.

BLUE CROSS OF KANSAS CITY and
BLUE CROSS ASSOCIATION

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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QUESTION PRESENTED

The National Health Planning and Resources Development Act of 1974, as amended, directs a Health Systems Agency (in this case a private Missouri corporation engaged in health planning activities) to "seek, to the extent practicable, to implement its HSP [Health Systems Plan] and AIP [Annual Implementation Plan] with the assistance of individuals and public and private entities in its health service area."

The question presented is whether this general statutory language is so inconsistent with the antitrust laws that it should be construed to grant a blanket exemption from those laws for a concerted refusal to deal by Blue Cross of Kansas City, Blue Cross Association, and other persons, where there was no involvement by a state or federal agency, where there was no state or federal mandate or supervision of the parties or conduct involved, and where the federal statute did not expressly immunize the boycott.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	iv
OPINIONS BELOW	1
JURISDICTION	2
STATUTORY PROVISIONS INVOLVED	2
STATEMENT	3
Proceedings Below	5
REASONS FOR GRANTING THE WRIT	7
I. The Court Below Has Decided An Important Question Of Federal Law Which Should Be Settled By This Court	7
A. The decision below, by largely displacing competition in the health care sector with unsupervised private action, presents an issue of critical national importance	7
B. Review of the decision below is required to clarify the ground rules governing antitrust liability in the health care industry	10
C. If allowed to stand, the decision below will impair the effect of recent decisions of this Court subjecting the health care industry to antitrust scrutiny	12
II. The Court Below Has Decided An Important Federal Question In A Way Which Is In Conflict With The Applicable Decisions Of This Court	15

Page

A. The decision below extends the doctrine of implied repeal to statutes involving no federal regulatory scheme whatever 16

B. The decision below would extend the doctrine of implied repeal to private voluntary conduct subject to no governmental oversight whatever 20

C. The decision below conflicts with the principles governing implied repeal established by this Court 23

CONCLUSION 26

ADDENDUM 27

APPENDIX A (Opinion of the Court of Appeals) 1a

APPENDIX B (Opinion of the District Court) 17a

APPENDIX C (Judgment of the Court of Appeals) 45a

APPENDIX D (Order Denying Petition for Rehearing) 47a

TABLE OF AUTHORITIES

	Page
CASES:	
American Medical Association v. *United States*, 130 F.2d 233 (D.C. Cir. 1942), *aff'd*, 317 U.S. 519	21
Ballard v. *Blue Shield of Southern West Virginia, Inc.*, 543 F.2d 1075 (4th Cir. 1976), *cert. denied*, 430 U.S. 922	13
Bates v. *State Bar of Arizona*, 433 U.S. 350	13
California v. *Federal Power Commission*, 369 U.S. 482	17,20,25
California Retail Liquor Dealers Association v. *Midcal Aluminum Co.*, 445 U.S. 97	13,19,22
Cantor v. *Detroit Edison Co.*, 428 U.S. 579	13
Carnation Co. v. *Pacific Westbound Conference*, 383 U.S. 213	16,22,25
City of Lafayette v. *Louisiana Power & Light Co.*, 435 U.S. 389	13
Doctor's, Inc. v. *Blue Cross of Greater Philadelphia*, 431 F. Supp. 5 (E.D. Pa. 1975), *aff'd per curiam*, 557 F.2d 1001 (3d Cir. 1976)	14
Eastern Railroad Presidents Conference v. *Noerr Motor Freight, Inc.*, 365 U.S. 127	27
Fashion Originators' Guild v. *Federal Trade Commission*, 312 U.S. 457	21
Federal Maritime Commission v. *Seatrain Lines, Inc.*, 411 U.S. 726	23,25
Feminist Women's Health Center, Inc. v. *Mohammad*, 586 F.2d 530 (5th Cir. 1978), *cert. denied*, 444 U.S. 924	13
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	Page
Goldfarb v. *Virginia State Bar*, 421 U.S. 773	13
Gordon v. *New York Stock Exchange, Inc.*, 422 U.S. 659	21-22
Group Life and Health Insurance Co. v. *Royal Drug Co.*, 440 U.S. 205	6,14-15
Hospital Building Co. v. *Trustees of Rex Hospital*, 425 U.S. 738	10,13,14
Hughes Tool Co. v. *Trans World Airlines*, 409 U.S 363	16,17,22
Huron Valley Hospital, Inc. v. *City of Pontiac*, 466 F. Supp. 1301 (E.D. Mich. 1979), *appeal docketed*, No. 79-1265 (6th Cir. May 16, 1979)	10,27
McLain v. *Real Estate Board of New Orleans*, 444 U.S. 232	14
Nankin Hospital v. *Michigan Hospital Service*, 361 F. Supp. 1199 (E.D. Mich. 1973)	13
National Broiler Marketing Association v. *United States*, 436 U.S. 816	15
National Railroad Passenger Corp. v. *National Association of Railroad Passengers*, 414 U.S. 453	25
National Society of Professional Engineers v. *United States*, 435 U.S. 679	13
New Motor Vehicle Board of California v. *Orrin W. Fox Co.*, 439 U.S. 96	13
North Carolina v. *P.I.A. Asheville, Inc.*, Civ. No. A-C-80-29 (W.D.N.C., filed February 22, 1980)	10,27-28
Northern Pacific Railway v. *United States*, 356 U.S.1	8
Otter Tail Power Co. v. *United States*, 410 U.S. 366	9,16,17, 20,22

	Page
Pan American World Airways, Inc. v. *United States*, 371 U.S. 296	16,22
Parker v. *Brown*, 317 U.S. 341	13
St. Bernard Hospital v. *Hospital Service Association of New Orleans, Inc.*, 618 F.2d 1140 (5th Cir. 1980)	14
St. Paul Fire and Marine Insurance Co. v. *Barry*, 438 U.S. 531	15
Silver v. *New York Stock Exchange, Inc.*, 373 U.S. 341	16,17,22, 23,24
Sound, Inc. v. *American Telephone & Telegraph Co.*, No. 80-1047 (8th Cir. Aug. 25, 1980)	19-20
Timken Roller Bearing Co. v. *United States*, 341 U.S. 593	12
Travelers Insurance Co. v. *Blue Cross of Western Pennsylvania*, 481 F.2d 80 (3d Cir. 1973), *cert. denied*, 414 U.S. 1093	14
United Mine Workers of America v. *Pennington*, 381 U.S. 657	27
United States v. *Borden Co.*, 308 U.S. 188	23-24,25
United States v. *National Association of Securities Dealers, Inc.*, 422 U.S. 694	17,20,21
United States v. *Philadelphia National Bank*, 374 U.S. 321	16,17,20, 22
United States v. *Radio Corporation of America*, 358 U.S. 334	20
United States v. *Sealy, Inc.*, 388 U.S. 350	12
United States v. *Topco Associates, Inc.*, 405 U.S. 596	12
Virginia Academy of Clinical Psychologists v. *Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980)	15

	Page
STATUTES, REGULATIONS AND LEGISLATIVE MATERIALS:	
15 U.S.C. § 1	2,13
15 U.S.C. § 2	2
15 U.S.C. § 1012	6,14
21 U.S.C. § 114d(1)	23
42 U.S.C. § 300k	4,6
42 U.S.C. § 300k(b)	17
42 U.S.C. § 300k-1	18
42 U.S.C. § 300k-2	9
42 U.S.C. § 300k-2(b)(3)	9
42 U.S.C. § 300k-3	18
42 U.S.C. § 300*l*	18
42 U.S.C. § 300*l*-1	4,17
42 U.S.C. § 300*l*-1(b)(1)(A)-(C)	4
42 U.S.C. § 300*l*-1(b)(4)	24-25
42 U.S.C. § 300*l*-2(c)(1)	2,6,7, 24
42 U.S.C. § 300*l*-2(g)	11
42 U.S.C. § 300*l*-4	18
42 U.S.C. § 300m	4,5,17 18
42 U.S.C. § 300m(d)	18
42 U.S.C. § 300m-2(a)(4)(A)	5
42 U.S.C. § 300m-2(a)(6)	11
42 U.S.C. § 300m-3	4,17
42 U.S.C. §§ 1320c *et seq.*	11
42 U.S.C. § 3532	23
42 U.S.C. § 4331	23
49 U.S.C. § 1639	23

	Page
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Mo. Ann. Stat. §§ 197.300 *et seq.* (Vernon Supp. 1980)	5
28 C.F.R. § 50.6	28
42 C.F.R. §§ 121.201 *et seq.*	18
S. Rep. No. 93-1285, 93d Cong., 1st Sess. 52, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7891	18-19
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Attorney General of Virginia, Business Review Letter, January 29, 1979	30
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	Page
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"The Hospital Industry's New Vulnerability to Antitrust," *Regulation,* Sept./Oct. 1980	10

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National Gerimedical Hospital and Gerontology Center ("National Gerimedical") respectfully prays that a writ of certiorari be issued to review the decision of the United States Court of Appeals for the Eighth Circuit in this case, entered on July 22, 1980.

OPINIONS BELOW

The Opinion of the United States Court of Appeals for the Eighth Circuit is reported at 628 F.2d 1050, and is set out below as Appendix A, *infra*, pp. 1a-15a. The Order of the District Court for the Western District of Missouri is reported at 479 F. Supp. 1012, and is set forth in Appendix B, *infra*, pp. 17a-44a.

JURISDICTION

The judgment of the United States Court of Appeals for the Eighth Circuit was entered on July 22, 1980, and is set out in Appendix C, *infra,* p. 45a. A petition for rehearing and rehearing en banc was denied on August 22, 1980. The order of denial is set out in Appendix D, *infra,* p. 47a.

The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Section 1 of the Sherman Act, 15 U.S.C. § 1, provides in pertinent part:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States or with foreign nations is declared to be illegal.

Section 2 of the Sherman Act, 15 U.S.C. § 2, provides in pertinent part:

> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony.

Section 300*l*-2(c)(1) of the National Health Planning and Resources Development Act, as amended, as it appears in 42 U.S.C., provides:

> A health systems agency shall implement its HSP and AIP, and in implementing the plans it shall perform at least the following functions:
>
> > (1) The agency shall seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area.

STATEMENT

This case involves a boycott of a nonprofit hospital by private health care reimbursement organizations. The facts before the court below may be summarized as follows:[1]

The petitioner, National Gerimedical, is a fully accredited, general acute care community hospital which opened on October 16, 1978. (D.R. at 2 and D.R. Supp. at 15.) It has been continuously licensed by the Missouri Division of Health since September, 1977, and has been fully certified as a Medicare provider by the Department of Health, Education and Welfare (now Health and Human Services) since its opening. (D.R. Supp. at 14.) One of the respondents, Blue Cross of Kansas City ("Blue Cross"), is a Missouri Health Services Corporation which markets and sells prepaid health reimbursement plans to the public, and contracts with health care providers to administer the plans. (D.R. at 2; 479 F. Supp. at 1015; App. B at 20a.) The other respondent, Blue Cross Association ("BCA") is a national organization to which local Blue Cross plans, including Blue Cross, belong. (D.R. at 2, 198.)

Prior to opening in 1978, petitioner sought to enter into a participating hospital agreement with Blue Cross. This was important to National Gerimedical's economic viability; participating hospitals receive directly one hundred percent reimbursement for covered hospital services rendered to Blue Cross subscribers, while reimbursement for covered services at nonparticipating hospitals is made, not to the hospital, but directly to the subscriber and only for up to eighty percent of the cost of the services. (D.R. at 4; 479 F. Supp. at 1015-16; App. B at 20a.) It was feared (and rightly so) that denial of participation would discourage Blue Cross subscribers from seeking services at National Gerimedical, thereby placing it at a substantial competitive disadvantage. (D.R. at 7; D.R. Supp.

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[1] Citations to the record below are to the Designated Record on Appeal, cited "D.R.", and to the Supplementary Designated Record on Appeal, cited "D.R. Supp."

at 19.) Blue Cross' individual members account for approximately one-fourth of all area hospital admissions, and all licensed general acute care community hospitals in Blue Cross' service area except National Gerimedical have Blue Cross participating contracts. (D.R. at 4, 261; 479 F. Supp. at 1015; App. B at 20a.)

On March 21, 1978, Blue Cross refused to enter into a participating hospital contract with National Gerimedical solely because it had not sought nor obtained a "finding of need" from the Mid-America Health Systems Agency ("MAHSA"), a private, not-for-profit Missouri corporation engaged in voluntary health planning activities which is funded as a health systems agency within the terms of the National Health Care Planning and Resources Development Act of 1974 ("Planning Act"), 42 U.S.C. §§ 300k *et seq.*[2] (D.R. at 5; 479 F. Supp. at 1016; App. B at 21a.) The "finding of need" requirement was imposed by Blue Cross pursuant to BCA policy guidelines adopted in 1976. (D.R. at 5.)

During the time at issue, no federal or Missouri law required National Gerimedical to seek or secure "need" review.[3] In addition, MAHSA had publicly declared that it would

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[2] The Planning Act established three types of health planning agencies. (*See* 42 U.S.C. §§ 300*l*-1, 300m, 300m-3.) The only type relevant here, Health Systems Agencies (HSAs), may be nonprofit, private corporations, public regional planning bodies, or single units of local governments. 42 U.S.C. § 300*l*-1(b)(1)(A)-(C). MAHSA, which is a private corporation, was conditionally designated by the Secretary of the Department of Health, Education, and Welfare (now Health and Human Services ("HHS")) as one of 205 regional health systems agencies under the Planning Act on April 12, 1976. (D.R. at 18.)

[3] At the time petitioner's complaint was filed and at all pertinent times, Missouri had neither enacted a compulsory certificate of need program, nor designated a State Health Planning and Development Agency in accordance with 42 U.S.C. § 300m. Both are prerequisites to any requirement under the Planning Act to seek "need" review by

(footnote continues)

disapprove the addition of any additional acute care hospital beds. (D.R. at 6; 479 F. Supp. at 1016; App. B at 21a.) For these reasons, National Gerimedical did not seek review by MAHSA, and Blue Cross thereafter denied the petitioner's request for participating hospital status solely because of its lack of a favorable "need" determination by MAHSA. (D.R. at 5; 479 F. Supp. at 1016; App. B at 21a.)

Proceedings Below

On May 23, 1978, National Gerimedical filed an antitrust complaint in the United States District Court for the Western District of Missouri against Blue Cross and BCA, in which it named MAHSA and others as non-defendant co-conspirators.[4] The complaint alleged that a collective refusal to deal by Blue Cross and BCA, acting in concert with the named non-defendant co-conspirators, constituted a violation of Section 1 of the Sherman Act, and that Blue Cross' actions, standing alone, violated Section 2 of that Act. (D.R. at 5-9; 479 F. Supp. at 1014; App. B at 17a-18a.)

On July 14, 1978, BCA and Blue Cross moved to dismiss the complaint on a variety of grounds. (479 F. Supp. at 1014;

(footnote continued)

the relevant HSA. *See* 42 U.S.C. § 300m-2(a)(4)(A). In August, 1979, Missouri enacted a Certificate of Need Law (Mo. Ann. Stat. §§ 197.300 *et seq.* (Vernon Supp. 1980)) which, by its terms, became fully effective in October, 1980. Under the provisions of that law, petitioner is deemed to have received a certificate of need for purposes of the state regulatory program. Despite this legislative determination, petitioner was denied participating hospital status by Blue Cross solely because it did not comply with Blue Cross' unilateral "need" review requirement.

[4] The other non-defendant co-conspirators named were all individuals who served simultaneously as members of the Board of Trustees of Blue Cross and the Board of Directors of MAHSA, or were employees of Blue Cross serving as members of the MAHSA Board of Directors, or were individuals employed by competitors of National Gerimedical who served on the Blue Cross Board of Directors.

App. B at 18a.) On November 2, 1979, the district court, treating the motion as one for summary judgment, held that the complaint stated a cause of action under Section 1; that the requisite effect on interstate commerce had been properly alleged; and that the conduct involved was not exempt from antitrust scrutiny under Section 2 of the McCarran-Ferguson Act (15 U.S.C. § 1012), as that exemption was construed by this Court during the pendency of this action in *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205. (479 F. Supp. at 1016-19, 1024-26; App. B at 22a-27a, 38a-42a.) Nevertheless, the district court granted summary judgment for defendants, finding that the Planning Act[5] created an implied "blanket exemption" from the antitrust laws for any and all voluntary private action "taken pursuant to the Act and clearly within the scope of the Act." (479 F. Supp. at 1021, 1024; App. B at 32a, 37a.) In so doing, it relied primarily on Section 300*l*-2(c)(1) of the Act which merely directs HSAs to seek the assistance of individuals, and public and private entities in implementing their health service plans,[6] and on the MAHSA plan itself, which states as objectives various cost containment goals. On this basis, the court concluded that "the certificate of need requirement voluntarily adopted by Blue Cross seems to be authorized by the Act as well as by the MAHSA Implementation Plan." (479 F. Supp. at 1021; App. B at 32a.) The court concluded that there was an irreconcilable conflict between the antitrust laws and the National Health Planning and Resources Development Act of 1974, which required not merely an

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[5] 42 U.S. §§ 300k *et seq.*

[6] Section 300*l*-2(c)(1) reads as follows:

> A health systems agency shall implement its HSP [Health Systems Plan] and AIP [Annual Implementation Plan], and in implementing the plans it shall perform at least the following functions:
>
> > (1) The agency shall seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area.

exemption for the specific conduct at issue, but rather a "blanket" exemption from the antitrust laws for any and all private actions ostensibly taken to further the public policy goals of the Act. (479 F. Supp. at 1021; App. B at 32a.)

The Court of Appeals, noting that the district court's finding of implied immunity for Blue Cross rested primarily on Section 300*l*-2(c)(1) of the Act (628 F.2d at 1052; App. A at 3a-4a), affirmed the decision.

REASONS FOR GRANTING THE WRIT

I

The Court Below Has Decided An Important Question Of Federal Law Which Should Be Settled By This Court.

The question involved in this case—the effect of the Planning Act on the antitrust laws—is one which will frequently recur. The issue is whether the broad, general language of that Act should be construed to provide a "blanket" exemption from the long-established antitrust laws.

Clearly, there is no express repeal. In considering whether there is an implied repeal, it should be emphasized that no state or federal agency of any kind was involved in the conduct at issue here. The decision of the court below, which creates a "blanket" exemption from the antitrust laws for purely voluntary conduct undertaken by private parties with no supervision by any public body, is one of great potential significance. Before its influence is allowed to spread, the decision below should be reviewed by this Court.

A. The decision below, by largely displacing competition in the health care sector with unsupervised private action, presents an issue of critical national importance.

A basic premise of the economic system established by Congress in its exercise of the commerce power is that "the

unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress." *Northern Pacific Railway* v. *United States,* 356 U.S. 1, 4. The decision below, by creating a "blanket" exemption for voluntary activities undertaken in ostensible pursuit of health planning goals, will have the effect of removing from antitrust scrutiny many activities of the health care sector—a sector which already accounts for almost one-tenth of this nation's total GNP[7] and represents the largest single component of the services sector of our economy.[8] It is also a sector of our economy which has experienced sharply rising costs,[9] a phenomenon which, at least in part, may be due to the substantial immunity from the antitrust laws that the health care sector and third-party reimbursement organizations such as respondent Blue Cross have enjoyed in the past. *See* C. Havighurst and G. Hackbarth,

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[7] *See* M. Freeland, G. Calat & C. Schendler, "Projections of National Health Expenditures, 1980, 1985, and 1990," *Health Care Financing Review,* Winter, 1980, 1, 6. Between 1965 and 1978, health care expenditures as a percentage of GNP rose from 6.2% in 1965 to 9.1% in 1978, and are expected to rise to 11.5% by 1990. *Id.* at 6. Growth has been especially great for the services funded by third parties such as respondent Blue Cross. Health Care Financing Administration, *Health Care Financing Trends,* Spring, 1980, at 1. Many commentators have identified the prevalence of third party reimbursement programs as a major factor in rapidly rising health care costs. *See, e.g.,* "Projections of National Health Expenditures," *supra,* at 6 & n. 6; A. Kahn, "Health Care and Inflation: Social Compassion and Efficient Choice," *National Journal,* Aug. 2, 1980, at 1-2; C. Havighurst, "Controlling Health Care Costs: Strengthening the Private Sector's Hand," *J. of Health Politics, Policy, and Law,* Spring 1976/Winter 1977, 471, 475, 478-79, 481.

[8] *Health Services Policy Session* (briefing book prepared by Federal Trade Commission Staff, 1979) at 1.

[9] *See, e.g.,* "Skyrocketing Health Care Costs: The Role of Blue Shield," Hearings before the Subcommittee on Oversight and Investigations of the House Committee on Interstate and Foreign Commerce, 95th Cong., 2d Sess. (1978). *See also* "Projections," note 7, *supra.*

"Competition and Health Care: Planning for Deregulation," *Regulation,* May/June 1980, 39, 43; A. Kahn, "Health Care Economics: Paths to Structural Reform," American Enterprise Institute Conference on Health Care, Washington, D.C., Sept. 25, 1980, at 11.

Congress has recently emphasized the important role competition must play in the health care industry if skyrocketing costs are to be brought down. In 1979 Congress specifically amended the Planning Act to emphasize its concern about "diminished" competition in the health care industry.[10] The 1979 Amendments added "the strengthening of competitive forces in the health services industry" to the Planning Act's list of national health priorities (Pub. L. No. 96-79, § 103(a), 93 Stat. 594-95 (1979), 42 U.S.C. § 300k-2), and directed HSAs to foster the effects of competition where competition appropriately allocates supply. (*Id.,* § 103(b)(3), 93 Stat. 595, 42 U.S.C. § 300k-2(b)(3)). Thus, Congress has recently affirmed its understanding that competition is to play a significant role in the delivery of health care services.[11]

As one commentator, discussing the impact of this case, has noted, "[i]t would be anomalous, moreover, if a statute designed to make use of competition were interpreted to invalidate the means to enforce it." F. Miller, "Antitrust and Certificate of Need: Health Systems Agencies, the Planning Act and Regulatory Capture," 68 *Georgetown L.J.* 873, 891 (1980). Yet, that is exactly what the court below did.

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[10] Health Planning and Resources Development Amendments of 1979, Act of October 4, 1979, Pub. L. No. 96-79, § 103(b)(1), 93 Stat. 592, 594-95 (1979).

[11] In *Otter Tail Power Co.* v. *United States,* 410 U.S. 366, 374, this Court found that similar legislation indicating "an overriding policy of maintaining competition to the maximum extent possible consistent with the public interest" was persuasive evidence that "Congress rejected a pervasive regulatory scheme . . . . in favor of voluntary commercial relationships" which were fully subject to the antitrust laws.

B. Review of the decision below is required to clarify the ground rules governing antitrust liability in the health care industry.

The decision below, if allowed to stand, will open the question of implied repeal in a wide range of factual circumstances in the health care industry. In fact, this Court has recently dealt with one of these factual situations in *Hospital Building Co.* v. *Trustees of Rex Hospital,* 425 U.S. 738.

In addition, there are currently pending cases presenting similar or related questions in the Sixth Circuit, *Huron Valley Hospital, Inc.* v. *City of Pontiac* (No. 79-1265, on appeal from the Eastern District of Michigan, 466 F. Supp. 1301 (1979)), and in the Western District of North Carolina, *North Carolina* v. *P.I.A. Asheville, Inc.* (Civ. No. A-C-80-29). These cases are summarized in the Addendum to this Petition, *infra,* pp. 27-28.

Further indication that this case is likely to stimulate many other cases in this area is provided by two recent Business Review Clearances by the Antitrust Division of the Department of Justice. These Executive determinations are likewise summarized in the Addendum, *infra,* pp. 28-30. In one of them, issued on May 6, 1980, the Department of Justice stated its views in these words:

> In essence, we do not believe that the Health Planning Act creates a complete antitrust exemption for all efforts by HSAs, and private parties working with HSAs, to implement health plans.

Not surprisingly, many in the health planning sector did not agree with the Department's position, thereby setting the stage for conflict between the health planning sector and the Department of Justice on the issue of implied repeal. *See* "The Hospital Industry's New Vulnerability to Antitrust," *Regulation,* Sept./Oct. 1980, at 12; L. Demkovich, "Scaring The Planners, " *National Journal,* May 31, 1980, at 905.

Moreover, the impact of the decision below is also likely to be felt in the forthcoming program of "appropriateness review," in which the HSA periodically reviews all institutional health services in its area, and makes recommendations to the State Health Planning and Development Agency concerning the "appropriateness" of such services. *See* 42 U.S.C. §§ 300*l*-2(g), 300m-2(a)(6). Under the decision below, any action taken by private parties—no matter how anticompetitive—which ostensibly serves the goals of this program would also be immune from antitrust scrutiny.

Nor is the impact of the broad approach of the court below necessarily confined to private actions undertaken in response to the policy goals outlined in the Planning Act. For example, the federal legislation establishing Professional Standards Review Organizations ("PSROs")(*see* 42 U.S.C. §§ 1320c *et seq.*), like the Planning Act, establishes and funds local, private organizations to implement federal cost-containment policy objectives in the health area. If the decision below is allowed to stand, the rationale utilized in this case could readily be used to support the contention that the PSRO legislation, like the Planning Act, creates a blanket exemption from antitrust scrutiny for all activities undertaken by the PSRO and those who arguably assist the PSRO in implementing the objectives of the PSRO legislation, despite the fact that the PSRO system, like the Planning Act scheme, is subject to significant antitrust abuse, and despite the fact that it is generally acknowledged that PSROs should not be considered immune from the antitrust laws. *See* C. Havighurst, "Professional Restraints on Innovation in Health Care Financing," 1978 *Duke L.J.* 303, 378 & n. 292 (1978); F. Grad, "The Antitrust Laws and Professional Discipline in Medicine," 1978 *Duke L.J.* 443, 482-84 (1978).

In short, the implied repeal issue presented in this case is a matter of major national concern. The decision below threatens to create inconsistent applications of the implied repeal doctrine to health planning activities in different sections of the country.

For example, in the Eighth Circuit, hospitals, under the decision below, would be able to allocate beds or services (activities which would clearly be illegal *per se* in the absence of the Planning Act),[12] or enter into virtually any other type of private "sharing" or other "cooperative" agreement with other hospitals under the guise of "planning." In other areas, many hospitals will probably be hesitant to participate in such "voluntary" sharing arrangements in light of the Justice Department's refusal to grant such schemes antitrust clearance under its Business Review procedure. *See* Addendum, *infra,* at pp. 28-30. Such inconsistency and uncertainty will not only have an adverse impact on the administration of the Planning Act,[13] but will also result in complex, time-consuming, and expensive litigation in the lower courts. Both of these results could be avoided by this Court's timely clarification of the implied repeal issue wrongly decided by the court below.

C. If allowed to stand, the decision below will impair the effect of recent decisions of this Court subjecting the health care industry to antitrust scrutiny.

Until very recently, health care providers and insurers were largely immune from the federal antitrust laws because of various legal hurdles which effectively shielded their conduct from antitrust scrutiny. *See, e.g.,* C. Havighurst, "Professional Restraints on Innovation in Health Care Financing," 1978 *Duke L.J.* 303, 343 (1978). Recent decisions of this Court have, however, greatly diminished these barriers.

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[12] *See, e.g., Timken Roller Bearing Co.* v. *United States,* 341 U.S. 593; *United States* v. *Sealy, Inc.,* 388 U.S. 350; *United States* v. *Topco Associates, Inc.,* 405 U.S. 596.

[13] *See* L. Demkovich, "Plus Ça Change," *National Journal,* Oct. 4, 1980, at 1664 ("specter of antitrust prosecution hangs over the hospitals that meet to work out such sharing arrangements"). Sharing arrangements are apparently widespread. *See* E. Taylor, "Participation in Shared Programs Up Sharply, Survey Discloses," 51 *Hospitals* 192 (July 16, 1977).

First, in *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773, and *National Society of Professional Engineers* v. *United States,* 435 U.S. 679, this Court rejected the contention that the "learned professions" are exempt from the requirements of the antitrust laws.

Second, in *California Retail Liquor Dealers Association* v. *Midcal Aluminum Co.,* 445 U.S. 97, and predecessor cases,[14] this Court significantly narrowed the *Parker* v. *Brown* [15] "state action" exemption, which now provides only a limited shield for private actions ostensibly taken by health professionals and third party insurers in response to state law and regulatory regimes. *See, e.g., Feminist Women's Health Center, Inc.* v. *Mohammad,* 586 F.2d 530, 549-50 (5th Cir. 1978), *cert. denied,* 444 U.S. 924; *Ballard* v. *Blue Shield of Southern West Virginia, Inc.,* 543 F.2d 1075, 1079 (4th Cir. 1976), *cert. denied,* 430 U.S. 922. Certainly after *Midcal* it is clear that private acts undertaken without state supervision are not exempt from antitrust scrutiny.

Third, and with special relevance to the health care industry, are this Court's recent decisions dealing with the scope of interstate commerce to which Section 1 of the Sherman Act (15 U.S.C. § 1) applies. For some time, hospitals and other health care providers have been able to contend successfully that the delivery of health services was a local activity, and, hence, not subject to the antitrust laws.[16] In *Hospital Building Co.* v. *Trustees of Rex Hospital,* 425 U.S. 738, however, this

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[14] *See Cantor* v. *Detroit Edison Co.,* 428 U.S. 579; *City of Lafayette* v. *Louisiana Power & Light Co.,* 435 U.S. 389; *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773. *See also Bates* v. *State Bar of Arizona,* 433 U.S. 350; *New Motor Vehicle Bd. of California* v. *Orrin W. Fox Co.,* 439 U.S. 96.

[15] 317 U.S. 341.

[16] *See, e.g., Nankin Hospital* v. *Michigan Hospital Service,* 361 F. Supp. 1199, 1210 (E.D. Mich. 1973)(no interstate commerce in suit by private hospitals against Blue Cross for revocation of participating hospital contract because "sale of hospital care is personal and localized in nature").

Court significantly broadened the scope of interstate commerce in antitrust scrutiny of the health professions and other health care providers. The scope of interstate commerce under the Sherman Act was further extended by this Court's more recent decision in *McLain* v. *Real Estate Board of New Orleans*, 444 U.S. 232.

The decision below would effectively undo this Court's decision in *Rex Hospital*. Like the present case, *Rex Hospital* involved private anticompetitive conduct ostensibly undertaken pursuant to health planning legislation. Under the present decision, the very conduct in *Rex Hospital* ultimately held on remand to have been in violation of the antitrust laws,[17] would be shielded from antitrust scrutiny—this time not by the statutory interstate commerce hurdle but rather by a much more amorphous "blanket" exemption tenuously based on the Planning Act.

The decision below would also significantly limit the impact of this Court's decision in *Group Life and Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205. In the past, antitrust suits against Blue Cross/Blue Shield were often held to be barred by Section 2 of the McCarran-Ferguson Act (15 U.S.C. § 1012), which exempts the "business of insurance" from the Sherman Act if such business is regulated by state law.[18] In *Royal Drug*, this Court, noting that "exempting

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[17] On August 18, 1980, a judgment for plaintiff in the amount of $7,320,090 was entered on a jury verdict in the *Rex Hospital* case. Post-judgment motions have been filed by defendants.

[18] *See, e.g., Travelers Ins. Co.* v. *Blue Cross of Western Pennsylvania*, 481 F.2d 80 (3d Cir. 1973), *cert. denied*, 414 U.S. 1093; *Frankford Hospital* v. *Blue Cross of Greater Philadelphia*, 417 F. Supp. 1104 (E.D. Pa. 1976), *aff'd per curiam*, 554 F.2d 1253 (3d Cir. 1977), *cert. denied*, 434 U.S. 860; *Doctors, Inc.* v. *Blue Cross of Greater Philadelphia*, 431 F. Supp. 5 (E.D. Pa. 1975), *aff'd per curiam*, 557 F.2d 1001 (3d Cir. 1976). *See also St. Bernard Hospital* v. *Hospital Service Ass'n of New Orleans*, 618 F.2d 1140 (5th Cir. 1980) (reversing lower court opinion holding participating hospital agreements immune from antitrust scrutiny in light of *Royal Drug*).

provider agreements from the antitrust laws would be likely in at least some cases to have serious anticompetitive consequences" (440 U.S. at 232, n. 40), concluded that pharmacy provider agreements were not within the McCarran-Ferguson Act exemption. Yet, the court below has rendered such agreements and all their surrounding circumstances totally exempt from antitrust scrutiny. The impact of this decision on other related McCarran-Ferguson Act issues, such as those involved in *Virginia Academy of Clinical Psychologists* v. *Blue Shield of Virginia,* 624 F.2d 476 (4th Cir. 1980), is less clear, but is not likely to be favorable to antitrust plaintiffs.

In short, the recent decisions of this Court have uniformly had the effect of narrowing the traditional antitrust exemptions applicable to health care providers and insurers.[19] What the opinion below does is to create a new blanket "Planning Act exemption" at least as broad as the antitrust exemptions traditionally used by health care providers and insurers (such as Blue Cross) to shield their conduct from antitrust scrutiny. Unless this Court's recent decisions are to be severely undercut, review of the decision below is required.

II

The Court Below Has Decided An Important Federal Question In A Way Which Is In Conflict With The Applicable Decisions Of This Court.

The decision below departs radically from the legal principles governing implied immunities from the antitrust laws as those principles have been established by this Court in a long

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[19] This has been consistent with the general inclination of this Court to read antitrust exemptions narrowly and to require a clear showing of Congressional intent before finding conduct exempt from antitrust scrutiny. *See, e.g., St. Paul Fire and Marine Ins. Co.,* v. *Barry,* 438 U.S. 531; *National Broiler Marketing Ass'n* v. *United States,* 436 U.S. 816.

line of decisions. Recognizing the "indispensable role of antitrust policy in the maintenance of a free economy," this Court has concluded that "[r]epeals of the antitrust laws by implication from a regulatory statute are strongly disfavored and have only been found in cases of plain repugnancy between the antitrust and regulatory provisions." *United States* v. *Philadelphia National Bank,* 374 U.S. 321, 348, 350-51. Moreover, even in the rare instances where such "plain repugnancy" has been recognized, any implied immunity is narrowly limited to that "necessary to make [the regulatory scheme] work, and even then only to the minimum extent necessary." *Silver* v. *New York Stock Exchange, Inc.,* 373 U.S. 341, 357. Consequently, this Court has repeatedly emphasized the need to reconcile the regulatory statute at issue with the antitrust laws, and has consistently rejected attempts (such as that by the court below) to carve out "blanket" exemptions to the antitrust laws. *Silver* v. *New York Stock Exchange, Inc.,* 373 U.S. 341, 357. *Accord, Pan American World Airways, Inc.* v. *United States,* 371 U.S. 296, 304-05; *Carnation Co.* v. *Pacific Westbound Conference,* 383 U.S. 213, 217-21; *Hughes Tool Co.* v. *Trans World Airlines,* 409 U.S. 363, 387, 389. *See also Otter Tail Power Co.* v. *United States,* 410 U.S. 366, 390 & n. 7 (Stewart, J., concurring in part and dissenting in part). The decision of the court below runs counter to an unbroken line of decisions by this Court, and fundamentally misconstrues the intent and meaning of the implied immunity doctrine.

A. The decision below extends the doctrine of implied repeal to statutes involving no federal regulatory scheme whatever.

The basic foundation of the implied immunity doctrine is the necessity to resolve conflicts between application of the antitrust laws and the statutory responsibilities of federal

regulatory agencies. As this Court noted in *United States* v. *National Association of Securities Dealers, Inc.*, 422 U.S. 694, 734:

> [I]mplied immunity [has been found] in particular and discrete instances to assure that the *federal agency entrusted with regulation in the public interest* could carry out that responsibility free from the disruption of conflicting judgments that might be voiced by courts exercising jurisdiction under the antitrust laws. (Emphasis added.)

The Planning Act creates no federal regulatory scheme at all in the sense that concept is employed in this area, much less a "pervasive" regulatory scheme of the kind this Court has repeatedly required before finding an implied repeal of the antitrust laws. *See Silver* v. *New York Stock Exchange, Inc.*, 373 U.S. 341, 347, 360-61; *Hughes Tool Co.* v. *Trans World Airlines*, 409 U.S. 363, 387; *Otter Tail Power Co.* v. *United States*, 410 U.S. 366, 374; *United States* v. *Philadelphia National Bank*, 374 U.S. 321, 352. *See also California* v. *Federal Power Commission*, 369 U.S. 482, 485.

The Planning Act was enacted "to facilitate the development of recommendations for a national health planning policy, to augment areawide and state planning for health service, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy." 42 U.S.C. § 300k(b). To accomplish that purpose, the Act established, through a series of grants made by the Department of Health, Education and Welfare [now the Department of Health and Human Services ("HHS")] a nationwide, three-tiered system of health planning and development organizations (*see* 42 U.S.C. §§ 300*l*-1, 300m, 300m-3), and encouraged the states to establish their own "certificate of need" programs to regulate the provision of new or ex-

panded health care services (*see* 42 U.S.C. § 300m).[20] The duties of the Secretary of HHS under this statutory scheme are limited,[21] and include no "regulatory" functions whatever. In short, the Planning Act established a framework for the future development of a national planning policy in which the only "regulatory" function would be served by each state pursuant to its own individualized "certificate of need" legislation.[22] The

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[20] Under the Act, a state is not required to participate in the planning program, but it faces the loss of various grants, loans or contract monies available from the federal government if it fails to do so. 42 U.S.C. § 300m(d).

[21] The primary responsibilities of the Secretary are to issue guidelines concerning national health planning goals (*see* 42 U.S.C. § 300k-1); to establish health service areas (*see* 42 U.S.C. § 300*l*); and to enter into designation agreements for HSAs and State Agencies (*see* 42 U.S.C. §§ 300*l*-4, 300m). The Planning Act also establishes a National Council on Health Planning and Development to advise and make recommendations to the Secretary for the development of national health planning guidelines (*see* 42 U.S.C. § 300k-3), pursuant to which the Secretary has promulgated planning guidelines intended to be used by the HSAs in developing their health plans (*see* 42 C.F.R. §§ 121.201 *et seq.*).

[22] This intention is reflected in the legislative history of the Act:

> Although the keystone to the health planning effort . . . is the areawide health planning agency, certain functions are more appropriately performed at the State level. Specifically . . . the performance of regulatory functions are most appropriately carried out at the State level. . . . [This] function can appropriately be carried out only by an agency of State government. The Committee bill is intended to encourage the establishment of a delicate but workable balance among the varied interests operating in the health care industry today. For that reason, rather detailed and explicit enumerations of the health planning and regulatory functions which can be

(footnote continues)

holding of the court below that this statute created a "blanket" antitrust exemption was based on a fundamental misreading of the implied immunity doctrine which will, if it remains uncorrected by this Court, breed additional uncertainty and confusion among the lower courts as to the basic scope of the implied immunity doctrine[23] and the relationship of that doctrine to the "state action exemption," which this Court only last term sought to clarify in *California Retail Liquor Dealers Association* v. *Midcal Aluminum Co.*, 445 U.S. 97.[24]

(footnote continued)

> carried out at the State level are contained in the legislation. To a very great extent, the manner in which those functions are performed is left to the discretion of the individual Governors of the States involved. [S. Rep. No. 93-1285, 93d Cong., 1st Sess. 52, *reprinted in* 1974 U.S. Code Cong. & Ad. News at 7891.]

[23] *See* "Antitrust and Regulated Industries: A Critique and Proposal for Reform of the Implied Immunity Doctrine," 57 *Tex. L. Rev.* 751, 760, 766 (1979)(noting that doctrine is in a state of confusion, and advocating clarification and reform of the criteria governing application of the doctrine).

[24] Confusion about the impact of the decision below is likely to be especially serious in the Eighth Circuit because of the Eighth Circuit's concurrent disposition of *Sound, Inc.* v. *American Telephone & Telegraph Co.*, No. 80-1047 (8th Cir. Aug. 25, 1980). At issue in *Sound, Inc.* were certain activities of AT&T which AT&T claimed were immune from antitrust scrutiny because the Federal Communications Act as implemented by the FCC had impliedly repealed the application of the antitrust laws to its challenged activities. *Sound, Inc.* and the instant case were the first cases dealing with the doctrine of implied repeal to be heard by the Eighth Circuit. Three days after the petition for rehearing *en banc* in the instant case was denied, *Sound, Inc.* was decided in Sound, Inc.'s favor. Hence, there now exist two Eighth Circuit decisions on implied repeal which are strongly opposed in their application of the principles governing implied repeal of the antitrust laws: the doctrine of implied repeal was held *inapplicable* to a situation involving a significant federal regulatory scheme in *Sound, Inc.*, while it was held *applicable* in the instant case

(footnote continues)

B. The decision below would extend the doctrine of implied repeal to private voluntary conduct subject to no governmental oversight whatever.

Under the principles established by this Court, voluntary private action, even where approved by a public agency with clear regulatory authority, does not necessarily provide antitrust immunity. *See, e.g., United States* v. *Radio Corporation of America,* 358 U.S. 334, 350-52; *California* v. *Federal Power Commission,* 369 U.S. 482, 485; *United States* v. *Philadelphia National Bank,* 374 U.S. 321, 350-52. *See also United States* v. *National Association of Securities Dealers, Inc.,* 422 U.S. 694, 744-45 (White, J., dissenting).

In this case, however, we do not have any public agency approval or acquiescence. Rather, we have a totally private scheme subject to no governmental oversight whatever, and "[w]hen these relationships are governed in the first instance by business judgment and not regulatory coercion, courts must be hesitant to conclude that Congress intended to override the fundamental national policies embodied in the antitrust laws." *Otter Tail Power Co.* v. *United States,* 410 U.S. 366, 374.

In this case, Blue Cross, acting in concert with BCA and others, determined that it would require a favorable "need review" from MAHSA before it would enter into a participating hospital contract. That decision was a voluntary one on the part of Blue Cross and BCA, and was not mandated or authorized by the Planning Act or by any government action, state or federal. MAHSA did not require defendants to do it, nor did MAHSA have the legal authority to approve or sanction the decision by Blue Cross and BCA, even if asked.

(footnote continued)

to a situation involving no federal regulatory scheme at all. This sets the doctrine of implied repeal on its head. Although petitioner requested a rehearing *en banc* in part to encourage the Eighth Circuit prospectively to reconcile its two decisions, the Eighth Circuit declined to do so.

Nor does National Gerimedical have available any relief from the adverse concerted action of Blue Cross, BCA, and others, for no mechanism for administrative or judicial review of voluntary "need" reviews exists under any law. For whatever reasons, Blue Cross and BCA undertook their conduct as if they were governmental agencies with a statutory mandate to limit competition and, in concert with participating Blue Cross hospitals and MAHSA, established a private regulatory system without any right of appeal or direct judicial review.

So far as we can determine, no such purely private action has ever been given antitrust immunity. The reason is clear. Antitrust is extraordinarily unsympathetic to "private government," whatever its motives. *See Fashion Originators' Guild* v. *Federal Trade Commission,* 312 U.S. 457 (involving collective action to bar state law torts), and *American Medical Association* v. *United States,* 130 F.2d 233 (D.C. Cir. 1942), *aff'd,* 317 U.S. 519 (involving new and allegedly "unethical" forms of practice).

This is especially important where immunity by implication is urged. Congress did not expressly grant antitrust immunity for the conduct at issue here, or to any similar conduct. That being so, it is not appropriate to presume a Congressional intention to oust the antitrust laws, with their goal of competitive efficiency, where such a conclusion is not compelled by an inconsistent scheme of public regulation designed to assure due process and mandated goals. For example, in *Gordon* v. *New York Stock Exchange, Inc.,* 422 U.S. 659, and *United States* v. *National Association of Securities Dealers, Inc.,* 422 U.S. 694, it was the fact of SEC regulatory oversight and authority that was crucial to this Court's conclusion that application of the antitrust laws would be inconsistent with Congressional intent. As Mr. Justice Douglas explained in his concurring opinion in *Gordon* (422 U.S. at 692):

> The antitrust laws are designed to safeguard a strong public interest in free and open competition, and

> immunity from those laws should properly be implied only when some equivalent mechanism is functioning to protect that public interest.

Similarly, in *Hughes Tool Co.* v. *Trans World Airlines, Inc.*, 409 U.S. 363, and *Pan American World Airways, Inc.* v. *United States*, 371 U.S. 296, it was the fact of active CAB oversight over the specific activity in question which was crucial to this Court's conclusion that the antitrust laws were not applicable.

On the other hand, where the private party is the real decision-maker, and where ouster of the antitrust laws will leave the public with neither antitrust nor adequate regulatory protection, neither this Court (nor any other court to our knowledge) has ever found a Congressional intent to exempt such conduct completely from antitrust scrutiny. *See Silver* v. *New York Stock Exchange, Inc.*, 373 U.S. at 353-54, 357;[25] *Otter Tail Power Co.* v. *United States*, 410 U.S. at 374-75; *Carnation Co.* v. *Pacific Westbound Conference*, 383 U.S. at 219; *United States* v. *Philadelphia National Bank*, 374 U.S. at 351. *Cf. California Retail Liquor Dealers Association* v. *Midcal Aluminum Co.*, 445 U.S. at 104-06.

Nevertheless, the court below implied a "blanket" exemption for purely voluntary conduct over which there is no public oversight of any sort. In effect, under the decision below, the application of the antitrust laws to private conduct could be defeated in many cases by a claim by the defendant parties that they undertook their anticompetitive conduct in support of the

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[25] As noted by this Court in *Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659, 683-84:

> In *Silver*, the Court concluded that there was no implied repeal of the antitrust laws in that factual context because the Exchange Act did not provide for SEC jurisdiction or review of particular applications of rules enacted by the exchanges. . . . [*T*]*here was no governmental oversight of the exchange's self-regulatory action, and no method of insuring that some attention at least was given to the public interest in competition.* (Emphasis added.)

public policy goals of enacted federal legislation.[26] This would be a clear distortion of the doctrine of implied repeal.

C. The decision below conflicts with the principles governing implied repeal established by this Court.

In numerous decisions, this Court has established and followed the principle that any implied immunity from the antitrust laws must be narrowly limited to that which is actually required to make the federal regulatory scheme work. *See, e.g., Silver* v. *New York Stock Exchange, Inc.*, 373 U.S. 341, 357; *United States* v. *National Association of Securities Dealers, Inc.*, 422 U.S. 694, 719-20; *Federal Maritime Commission* v. *Seatrain Lines, Inc.*, 411 U.S. 726, 731-36; *United States* v.

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[26] Many other federal statutes have general "cooperation" provisions similar to the provision relied on by the court below, which could conceivably be placed in issue by the decision below. *See, e.g.*, 42 U.S.C. § 4331 (referring to the "continuing policy of the Federal Government, in cooperation with state and local governments and other concerned public and private organizations, to use all practicable means and measures, including financial and technical assistance, in a manner calculated to foster and promote the general welfare, to create and maintain conditions under which man and nature can exist in productive harmony, and fulfill the social, economic, and other requirements of present and future generations of Americans"); 21 U.S.C. § 114d(1) (authorizing the Secretary of Agriculture "to cooperate with other public and private organizations and individuals" in carrying out purposes of the Act); 42 U.S.C. § 3532 (authorizing the Secretary of HUD to "encourage comprehensive planning by the state and local governments with a view to coordinating Federal, State, and local urban and community development activities; [and] encourage private enterprise to serve as large a part of the Nation's total housing and urban development needs as it can and develop the fullest cooperation with private enterprise in achieving the objectives of the Department"); 49 U.S.C. § 1639 (authorizing the Secretary of Transportation to "consult and cooperate, as he deems appropriate, with institutions and private industry").

Borden Co., 308 U.S. 188, 198-200. Consequently, blanket exemptions have been uniformly disapproved by this Court. *See Silver* v. *New York Stock Exchange, Inc.*, 373 U.S. 341, 357, and cases cited *supra*, at p. 16.

In this case, the court below found a conflict between the antitrust laws and the general declaration in Section 300*l*-2(c)(1) of the statute (*see* p. 6, *supra*) despite the fact that that section contains no reference to third party payors such as Blue Cross, and despite the fact that MAHSA never sought the assistance of Blue Cross in the enforcement of its "need" standards. If anything, Blue Cross relied on MAHSA and MASHA's planning activity to justify its own unilateral decision to deny participating hospital status. In short, the court below, despite the consistent directives of this Court, did not attempt to reconcile the provision at issue with the antitrust laws, or to read the provision narrowly so as to avoid an unneccessary conflict with the antitrust laws. Instead, it went out of its way to find a conflict in direct contravention of the precedents of this Court, and then, after it had done so, it used that "conflict" to justify a blanket exemption from the antitrust laws—a result which this Court has specifically ruled to be unacceptable (*see, supra*, at p. 16), and which at least one commentator has emphasized "conflicts with [this Court's] restrictive approach to implied repeal." F. Miller, "Antitrust and Certificate of Need: Health Systems Agencies, the Planning Act, and Regulatory Capture," 68 *Georgetown L.J.* 873, 891 (1980).

The error of the decision below, and its conflict with the decisions of this Court, is made even clearer by the specific limited express immunity from the antitrust and other federal laws contained in the Planning Act.[27] Significantly, that immunity is limited to an "individual" who is either a "member or

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[27] At all times here pertinent 42 U.S.C. § 300*l*-1(b)(4) provided:

> No individual who, as a member or employee of a health systems agency, shall, by reason of his performance of any duty, function, or activity required of, or authorized

(footnote continues)

employee" of an HSA, and even then it is limited to conduct "required of, or authorized to be undertaken by, the agency." Obviously, this provision provides no solace to Blue Cross or BCA.

This limited express immunity shows that Congress knew what immunity it wanted to give and did so. This Court has held that it is a basic rule of statutory interpretation—the modern expression of the ancient doctrine of *expressio unius est exclusio alterius*—that the specific statement of a power or exemption is the exclusion of any others. *National Railroad Passenger Corp.* v. *National Association of Railroad Passengers,* 414 U.S. 453, 458. This rule of construction, strong in its own right, is particularly important in antitrust law. Since implied repeals of the antitrust laws are strongly disfavored, this Court has emphasized that where Congress has provided only a narrow and limited immunity, no broader immunity can be inferred. *See Federal Maritime Commission* v. *Seatrain Lines, Inc.,* 421 U.S. at 733; *California* v. *Federal Power Commission,* 369 U.S. at 485; *Carnation Co.* v. *Pacific Westbound Conference,* 383 U.S. at 216-17. Similarly, in *United States* v. *Borden Co., supra,* this Court found that the explicit immunity provisions contained in the Agricultural Marketing Agreement Act defined how far Congress intended that Act should operate to

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(footnote continued)

> to be undertaken by, the agency under this subchapter be liable for the payment of damages under any law of the United States or any State (or political subdivision thereof) if he has acted within the scope of such duty, function, or activity, has exercised due care, and has acted, with respect to that performance, without malice toward any person affected by it.

This provision was amended in 1979, but the amended provision also limits immunity to members of the governing body and employees of an HSA. Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, § 110(d)(1), 93 Stat. 603-04 (1979).

render the Sherman Act inapplicable, concluding (308 U.S. at 201):

> If Congress had desired to grant any further immunity, Congress doubtless would have said so.

This reasoning is clearly applicable here, and sharply illustrates the failure of the decision below to conform to the prior decisions of this Court.

CONCLUSION

The decision below presents an issue of public importance which should be decided by this Court, and the decision is in conflict with decisions of this Court.

The petition for certiorari should be granted.

Respectfully submitted,

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ADDENDUM

A. Cases Involving Implied Repeal Now Pending in Lower Courts.

1. *Huron Valley Hospital, Inc.* v. *City of Pontiac*, 466 F. Supp. 1301 (E.D. Mich. 1979), *appeal docketed*, No. 79-1265 (6th Cir. May 16, 1979).

In this case, plaintiff wanted to construct a new hospital and sought approval for such construction, as required by state law. Its application was denied. Six months later, a competing hospital submitted an application for the renovation of its existing facilities. The HSA and the State Agency approved the competing hospital's application. Plaintiff then sued under the antitrust laws, alleging, *inter alia*, that the competing hospital had conspired with the HSA, the State Health Planning and Development Agency, and a health planning group to exclude it from the market. The district court dismissed the action, holding that the state action exemption, the doctrine of implied repeal, and the *Noerr-Pennington* doctrine[28] all insulated the parties' action from antitrust challenge.

2. *North Carolina* v. *P.I.A. Asheville, Inc.*, Civ. No. A-C-80-29 (W.D.N.C., filed Feb. 22, 1980).

In this case the state alleged that defendant had engaged in a conspiracy to eliminate competition in the rendition of private psychiatric hospital services by, *inter alia*, seeking to acquire two additional hospitals in the relevant market area. Under the applicable state legislation, such acquisitions were subject to the approval of the State Health Planning and Development Agency. In its motion for judgment on the pleadings, the defendant contended that its actions were immune from the antitrust laws under the implied immunity, state action and *Noerr-Pennington* doctrines. In addition, defendant contended

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[28] *Eastern R.R. Presidents Conference* v. *Noerr Motor Freight, Inc.*, 365 U.S. 127; *United Mine Workers* v. *Pennington*, 381 U.S. 657.

that the primary jurisdiction doctrine required that the case be stayed until the State Agency had ruled on defendant's application. The district court stayed the action pending the State Agency decision.

B. Statements of Enforcement Intentions by the Department of Justice, Antitrust Division (28 C.F.R. § 50.6).

1. Central Virginia Health Systems Agency Business Review Clearance.

This statement was prompted by a January 25, 1979, letter from the Central Virginia Health Systems Agency, seeking a statement of the Department's enforcement intentions with respect to planning-related activities of the HSA and health care providers in the HSA's service area. The Department, in a letter dated May 6, 1980,[29] concluded that certain of the activities proposed by CVHSA appeared to be contemplated by the Act and said it had no intention of challenging such activities so long as they corresponded to the statutory scheme. However, the Department declined to find that the Planning Act created a complete exemption for all efforts by health systems agencies and private parties working with them to implement their plans. It said:

> [W]e believe that agreements among competing hospitals limiting the number of patients they could serve or the kinds of services they could offer in the absence of conscious and explicit authorization and supervision by the State are probably not contemplated by the Act nor exempt from the application of federal antitrust laws.
>
> * * *
>
> *In essence, we do not believe that the Health Planning Act creates a complete antitrust exemption*

[29] Department of Justice Press Release, May 8, 1980, summarized in *Trade Reg. Rep.* (CCH), May 12, 1980, at 5.

> *for all efforts by HSAs, and private parties working with HSAs, to implement health plans.* An antitrust exemption protecting all activities which arguably furthered the general statutory goals is not, in our view, justified. *The legislative history of the Act reveals no congressional intent to restrict the operation of the antitrust laws to such an extent. Moreover, that interpretation would clearly conflict with the well-established principle that implied repeal of the antitrust laws is disfavored and that antitrust exemptions should be construed narrowly.* [Emphasis added.]

2. Westlake Hospital Business Review Clearance.

This statement, issued by the Justice Department on August 27, 1980,[30] involved a proposed agreement between the Westlake Hospital Campus Association, Westlake, Ohio, and Lakewood Hospital, Lakewood, Ohio, in settlement of lawsuits between the two institutions, which provided that the Association would not offer specified health care services at its hospital for a certain period of time. The Department declined to grant the requested clearance. It said:

> Agreements between competitors as to the products or services that each will offer are prohibited by the antitrust laws because of their plainly anticompetitive purpose and effect. State and federal regulatory programs reflect a legislative judgment that if competition is to be restrained, it should be restrained by the appropriate regulatory agencies, and not by private agreements. The agreement has not been authorized or required by any regulatory agency and is not subject to governmental supervision. It has not been addressed by the health systems agency plan

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[30] Department of Justice Press Release, August 29, 1980, summarized in *Antitrust & Trade Reg. Rep.* (BNA), September 11, 1980, at A-12.

> and has not been authorized or required by the health systems agency or the state health planning and development agency. Moreover, the agreement may limit the effectiveness of the state's regulatory program, since the state may be denied the opportunity to consider a Certificate of Need Application from an otherwise qualified applicant. *These considerations also preclude application of any implied antitrust exemption that may arise from the National Health Planning and Resources Development Act, 42 U.S.C. § 300k et seq., from which the state regulatory scheme is derived.* Accordingly, the Department cannot state an intention not to sue to enjoin the proposed agreement. [Emphasis added.]

C. Statement of Enforcement Intentions by the Attorney General of Virginia

In a business review letter issued January 29, 1979,[31] the Attorney General of Virginia declined to clear a plan whereby hospitals would enter into agreements allocating beds for obstetrical services among themselves pursuant to a request by the HSA that they do so. The attorney general concluded that the proposed conduct was not exempt from the state antitrust laws:

> The conduct you propose is not part of the State Health Plan, it has not been approved by any State or federal agency, it is neither required nor compelled by either the Act or its State counterpart, or any agency of either. Consequently, the conduct is not expressly exempt from the reach of the Virginia Antitrust Act. Moreover, since the conduct is not necessary to the regulatory framework established by the Act, it is not impliedly exempt from the reach of the antitrust laws.

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[31] This letter is summarized in *Antitrust & Trade Reg. Rep.* (BNA), March 1, 1979, at D-5 and D-6.

APPENDIX A

OPINION OF THE COURT OF APPEALS

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 79-2018

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER,
Appellant,

v.

BLUE CROSS OF KANSAS CITY, BLUE CROSS ASSOCIATION,
Appellees.

(Filed July 22, 1980)

Before STEPHENSON and MCMILLIAN, Circuit Judges, and SACHS, *District Judge.

STEPHENSON, Circuit Judge

The National Gerimedical Hospital, plaintiff-appellant, appeals from a summary judgment granted to defendant-appellee Blue Cross of Kansas City. National had charged Blue Cross and others[1] with violations of sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2. The trial court[2] found Blue Cross' activities to be taken pursuant to Public Law 93-641, the National Health Care Planning and Resources Development Act of 1974, 42 U.S.C. § 300k, *et seq.;* that there was a repugnancy between the Act and the antitrust laws; and that consequently, under the doctrine of implied immunity, Blue Cross' activities were immune from the antitrust laws. *National Gerimedical Hospital & Gerontology Center* v. *Blue Cross,* 479 F. Supp. 1012 (W.D. Mo. 1979). We affirm the district court.

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* The Honorable Howard F. Sachs, United States District Judge for the Western District of Missouri, sitting by designation.

[1] Blue Cross of Kansas City and Blue Cross Association were named defendant coconspirators. There were several nondefendant coconspirators listed in the plaintiff's complaint, including Mid-America Health Systems Agency, Inc. (MAHSA).

[2] The Honorable Russell G. Clark, United States District Judge for the Western District of Missouri.

I. Statutory Background

The related health care statutes, as they existed during the relevant time period, are as follows.

Prior to the National Health Care Planning and Resources Development Act of 1974, the Public Health Service Act, 42 U.S.C. § 291, *et seq.* (known as the Hill-Burton Act) was the primary legislation channeling federal funds to states in support of construction and modernization of health care facilities. The Hill-Burton Act provides, as does much federal legislation involving state cooperation, for voluntary participation by the states. The participating state submits a state plan to HEW, which designates a particular state agency to be in charge of administering the state program and determining, *inter alia,* the need for new or expanded health care facilities. While an applicant could build without approval by the state agency, such applicant would not be eligible for reimbursement by the federal government. *Lakeside Mercy Hospital, Inc.* v. *Indiana State Board of Health,* 421 F. Supp. 193, 196-97 (N.D. Ind. 1976).

Other prior legislation providing for channeling federal funds into health care programs includes the Public Health Service Act § 314, 42 U.S.C. § 246 (amended 1978 and 1979). Under this program, federal funds are channeled to participating states that submit, and have approved by HEW, a Comprehensive Health Planning State Plan. This legislation provides for a state agency to be designated to screen health care applications in order to verify the need for new facilities and programs under the approved state plan, and also, in cooperation with the state agency, the Act provides for Area Comprehensive Health Planning Agencies. *Id.* at 197.

Section 1122 of the Social Security Act, 42 U.S.C. § 1320a-1 (amended 1978 and 1979), enacted in 1972, provides for a participating state program for repayment provisions for Medicaid and Medicare, for which repayment prior to that time had

not been dependent upon need approval by any of the various state health agencies (those designated by the state pursuant to compliance with federal requirements in order to be a participating state). Section 1122 of the Social Security Act authorizes HEW to enter into agreements with participating states whereby a state agency is designated as a health planning agency. This agency develops a state plan and makes recommendations as to the need of proposed expenditures for health care facilities, in conformity with regulations promulgated by HEW. Once final approval by HEW is received, the capital expenditure qualifies for purposes of reimbursement, via Medicaid and Medicare payments, the portion of fees allocable to return of depreciation, debt service and other capital related expenditures. *Id.*

The purpose of the National Health Care Planning and Resources Development Act of 1974, also providing for a participating state program, is "to facilitate the development of recommendations for a national health planning policy, to augment areawide and State planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy." 42 U.S.C. § 300k(b).

Part B of the Act, 42 U.S.C. § 3001, provides for the establishment of health service areas and corresponding health systems agencies (HSAs). The purposes of the HSAs as stated in the Act include, *inter alia,* "preventing unnecessary duplication of health resources." 42 U.S.C. § 300*l*-2(a). In order to accomplish its purposes, the HSA is to establish a health systems plan (HSP) and an annual implementation plan (AIP) which will achieve the goals of the HSP. 42 U.S.C. § 300*l*-2(b)(2). The Act specifically provides that the HSA shall implement the HSP and AIP, and "*shall* seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area." 42 U.S.C. § 300*l*-2(c)(1) (emphasis added). It

is this section of the Act upon which the district court primarily rests its finding of antitrust immunity for the actions of Blue Cross.

II. Facts

Construction of the National Gerimedical Hospital began in August 1976 and was completed in September 1978. On October 4, 1977, Hospital submitted to Blue Cross a request for a member hospital contract. Pursuant to such contracts Blue Cross reimburses individual members the cost of all covered health services received at member hospitals. If health services are received by individual members at nonmember hospitals, Blue Cross individual members receive only up to eighty percent of the cost of the covered medical services. Also, for health services received at member hospitals, Blue Cross reimburses or pays the hospital for the services provided its individual members; with a nonmember hospital, the reimbursement is paid to the individual member, not to the hospital.

Blue Cross advised Hospital that Hospital must first secure need approval of Mid-America Health Services Agency (MAHSA) in order to be eligible for favorable consideration by Blue Cross for a member hospital contract.

MAHSA, named as a non-defendent alleged coconspirator,[3] is a private not-for-profit Missouri corporation engaged in voluntary health planning. MAHSA was conditionally designated an HSA under the Act and was notified of its designation for the eight county bi-state region of the metropolitan Kansas City area by letter from HEW on April 7, 1976. *Mid-America Regional Council* v. *Mathews,* 416 F. Supp. 896, 899 (W.D. Mo. 1976). Thus during the relevant time period of this case, MAHSA enjoyed this status.

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[3]*See* note 1 *supra.*

Prior to this time period, Missouri had participated in the Social Security Act § 1122 Capital Health Care Expenditures Program, which included a State Planning Agency that performed section 1122 program reviews, as discussed *infra.* 42 U.S.C. § 1320a-1 (amended 1978 and 1979). Blue Cross had required that large capital expenditures be approved by the local and regional planning arm of the section 1122 State Planning Agency before, *i.e.,* a hospital could be a member institute. This Capital Expenditure Program, as discussed *infra,* was designed to assure that federal funds appropriated for Medicaid and Medicare were not used to support unnecessary capital expenditures for health care facilities.

Area agencies established under 42 U.S.C. § 246 (amended 1978 and 1979), discussed *infra,* Area Comprehensive Health Planning Agencies (CHPs), were used in conjunction with the need approvals necessary under 42 U.S.C. § 1320a-1 (amended 1978 and 1979). The applicant for Medicaid and Medicare cost reimbursement had to seek a favorable recommendation from the CHP and secure a favorable determination of need from the state planning agency, the Missouri State Health Planning and Development Agency. The CHP for Missouri was MAHSA. The National Health Planning and Resources Development Act of 1974 gives preference to § 246 area agencies, CHPs and existing regional planning areas. 42 U.S.C. § 300*l*-4(b)(4) and § 300*l*(a)4.

On June 30, 1976, Missouri, a participating state under 42 U.S.C. § 1320a-1 (amended 1978 and 1979) since 1973, refused to renew Missouri's contract with HEW and Missouri's Program for Capital Health Care Expenditures was terminated.

On July 21, 1976, as reflected by a "Special Newsletter" to Blue Cross member hospitals in Missouri, Blue Cross gave notice that all projects in the Kansas City metropolitan area not reviewed and approved by MAHSA would not be reimbursible by Blue Cross of Kansas City.

> Blue Cross of Kansas City has been observing with considerable interest the events regarding the State of

Missouri's cancellation of the SSA-1122 Capital Expenditure Program. It appears at this time that the final position of the Department of Health, Education, and Welfare on this matter has not been clarified with respect to reimbursement sanctions.[4] It also appears that the State of Missouri has no intention of reinstating the State Comprehensive Health Planning Agency to perform the SSA-1122 program review.

In view of this action, the Provider Relations Committee of the Blue Cross Board of Trustees felt it necessary to advise all Missouri Member Hospitals of our position on this matter. As you are aware, the Member Hospital Contract contains a provision that capital expenditures of over $350,000 or 5% of the hospital's operating expense in the most recent fiscal year, whichever is lesser, be approved by the local or regional planning agency. Since the State Planning Agency no longer exists, Blue Cross of Kansas City will look to the local Health Systems Agency for approval of such capital projects. That Health Systems Agency in the Kansas City metropolitan area is the Mid-America Health Systems Agency and in the balance of our operating area, Area II Health Systems Agency. *All projects not reviewed and approved by these Health Systems Agencies will not be reimbursible by Blue Cross of Kansas City.*

Therefore, we urge you to continue working with these agencies and Blue Cross of Kansas City in future planning needs for your hospital. Should you have any questions regarding our position on this matter, please do not hesitate to consult with us.

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[4] Appellant advises us that no question has been raised concerning Hospital's entitlement to full Medicare reimbursement.

MAHSA was, of course, designated as the HSA under the Act. However, Missouri, during the relevant time period, had no law implementing the Act in Missouri nor designating any state agency thereunder in accordance with 42 U.S.C. § 300m.

MAHSA had publicly stated that it would disapprove and not consider favorably the addition of any acute care hospital beds; acute care hospital beds are the type Hospital provided; Hospital did not submit an application for need review to MAHSA; Hospital's application for a member contract with Blue Cross was denied in March 1978 by Blue Cross because Hospital had not received approval through the voluntary health planning process as required by the Special Newsletter. Hospital then filed this lawsuit.

III. Analysis

National argues that by requiring National to get need approval from MAHSA before it applies for a member hospital contract with Blue Cross, Blue Cross violates the antitrust laws. National contends that the requirement constitutes a contract, combination or conspiracy in restraint of trade, Sherman Act § 1, 15 U.S.C. § 1, and an abuse of Blue Cross' monopoly power in the private health care reimbursement plan market, Sherman Act § 2, 15 U.S.C. § 2.

What defeats National's otherwise appealing argument are the specific provisions of the National Health Planning and Resources Development Act for voluntary cooperation and assistance of private entities and persons in the community and health care market. While the doctrine of implied immunity is to be used sparingly and only when necessary, *Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659 (1975), these provisions make the instant situation one well-suited for its use.

The necessity of application of the doctrine of implied immunity arises if there is (1) a clear repugnancy between the antitrust laws and the specific conduct at issue and (2) if the

intent of Congress is that implied repeal of the antitrust laws was intended. *Essential Communication Systems, Inc.* v. *AT&T,* 446 F. Supp. 1090, 1094-95 (D.N.J. 1978).

As to the first prerequisite, the district court herein stated its finding of repugnancy best when it stated:

> If the Court were to find that private business working in conjunction with the health systems agency established by the Act in their area to achieve the goals of the Act were liable or might be liable under the antitrust laws for their action, then * * * the accomplishment of the purpose of the goals of the Act would be effectively foreclosed.

National Gerimedical Hospital & Gerontology Center v. *Blue Cross, supra,* 479 F. Supp. 1012, 1021 (W.D. Mo. 1979).

National's emphasis upon the fact that Missouri was not a participating state—"at all times here pertinent, Missouri had no law implementing P.L. 93-641 in Missouri nor designating any state agency thereunder in accordance with 42 U.S.C. § 300m" (brief for appellant at 12-13)—misses the focus of the doctrine of implied immunity. The doctrine should not be confused with the state action exemption to the antitrust laws as articulated in *Parker* v. *Brown,* 317 U.S. 341 (1943). The doctrine of implied immunity, in fact,

> is actually a subspecie of implied statutory repeal. *See, Gordon* v. *N.Y. Stock Exchange,* 422 U.S. 659, 682, 95 S.Ct. 2598, 45 L.Ed.2d 463 (1975), and *U. S.* v. *Southern Motor Carriers Rate Conference,* 439 F. Supp. 29, 35 (N.D. Georgia, 1977). It is one of several distinct judicially created rules, which include "primary jurisdiction" and "exhaustion of administrative remedies", designed to resolve potential conflicts between two regimes with federal statutory authorization to regulate the conduct of business

> entities: federal administrative agencies and federal courts enforcing (among others) the antitrust laws.
>
> The antitrust laws posit that the public interest is best served when business enterprises are compelled to compete in markets free of anti-competitive restraints. In contrast, the basic premise of administrative regulation is that the freedom of business entities must be in some degree curtailed to maximize the general welfare. When the same conduct falls within the scope of both the antitrust laws and a regulatory scheme, potential conflicts of competency and policy are resolved under the doctrine of implied immunity.

Essential Communication Systems, Inc. v. *AT&T, supra,* 446 F. Supp. at 1094 (footnote omitted). Missouri's lack of state participation did not affect the Act which set up a regulatory scheme which designated MAHSA as a regulatory need review agency. More specifically, it has no effect upon that portion of the legislation which calls for a regulatory system which included the designated HSA implementing the HSP and AIP "with the assistance of individuals and public and private entities in its health service area." 42 U.S.C. § 300*l*-2(c)(1).

The extent of this regulatory scheme is demonstrated by the district court's discussion.

> Mid-America Health Systems Agency was one of 205 regional health systems agencies established under the Act * * *. In November of 1977 Mid-America Health Systems established a health systems plan for 1978 through 1982 in this region. Increasing hospital costs and unnecessary duplication of facilities and equipment were considered two of the biggest problems in this region. The health systems plan adopted by Mid-America Health Systems recognized:

> Problem—The acute inpatient care system does not function in a coordinated manner which is cost-effective in the delivery of acute care services at the most appropriate level consistent with quality standards. (Health Systems Plan at pp. 6-19.)

The goal in this area was recognized as:

> Goal: Improve the health of the population in the MAHSA area through an adequately available and accessible acute inpatient care system coordinated in a manner that fosters containment of health care costs and provides quality of care in a culturally acceptable manner. (Health Systems Plan at pp. 6-19.)

To implement this goal MAHSA established a number of objectives in this area and specified particular methods that could be utilized to achieve each objective. Objective No. 4 seeks to:

> **Objective #4**
>
> Maintain a rate of increase in total expenditures for hospital care services which does not exceed the rate of increase in the medical care services component of the Consumer Price Index. (Health Systems Plan at pp. 6-21.)

As one of the nine methods set forth to meet this goal, Mid-America Health System suggested:

> (6) Third party payors and the hospital community should work together to develop uniform reporting systems and procedures such that meaningful hospital-to-hospital and year-to-year hospital cost and service-by-service utilization comparisons can be made. (Health Systems Plan at pp. 6-22.)

National Gerimedical Hospital & Gerontology Center v. *Blue Cross, supra,* 479 F. Supp. at 1020-21. Implied immunity can be found in "particular and discrete instances to assure that the

federal aqency entrusted with regulation in the public interest could carry out that responsibility free from the disruption of conflicting judgments that might be voiced by courts exercising jurisdiction under the antitrust laws." *United States* v. *National Association of Securities Dealers, Inc.*, 422 U.S. 694, 734 (1975).

We agree with the district court's finding of clear repugnancy between the Act and the antitrust laws, as the Act and regulatory scheme clearly call for the action which has now become the basis of an antitrust claim.

We now examine the history of the Act in order to determine the congressional intent in regard to immunity. The district court concluded, after a thorough review of the legislative history, that it was the intent of Congress to immunize this type of voluntary action from the antitrust laws. We cannot improve on the district court's discussion:

> In essence the antitrust laws posit that the public interest will be served best when business enterprises are compelled to compete in markets free of anti-competitive restraints. * * * The concern of the Senate Committee that considered the health care legislation at issue here was the failure of the health care industry to "respond to classic marketplace forces." See Volume 4, U.S. Code Cong. & Admin. News at p. 7878, U.S. Code Cong. & Admin. News 1974, p. 7878. In the Committee's view:
>
> > The highly technical nature of medical services together with the growth of third party reimbursement mechanisms act to attentuate the usual forces influencing the behavior of consumers with respect to personal health services. For the most part, the doctor makes purchasing decisions on behalf of the patient and the services are frequently reimbursed under health insurance programs, thus reducing the patient's

> immediate incentive to contain expenditures. Volume 4, U.S. Code Cong. & Admin. News at p. 7878.

The Committee expressed concern over increasing hospital costs and improper utilization of existing facilities. Volume 4, U.S. Code Cong. & Admin. News at pp. 7893-4. The Committee in fact stated:

> The recent rapid acceleration in the costs of personal health services, far outstripping the rate of inflation in other sectors of the economy, has caused the Committee great concern. Althouqh recognizing the increase in costs experienced by health care providers attributable to general inflation, the Committee wishes to express its concern with respect to the disproportionately high rate of increase in costs of health care services. Volume 4, U.S. Code Cong. & Admin. News at p. 7895.

The Committee attributed many of the cost and duplication problems in the health care industry to reimbursement programs like the ones these defendants sponsor. The legislative history indicates to this Court that any attempts by companies such as these defendants to reduce costs and duplication were to be welcomed and were considered essential to a successful program of cost reduction. In summarizing the Act, the Committee stressed:

> The long-range goal plan is expected to provide for the prevention of unnecessary duplication of resources and assure that quality health services will be available and accessible in a manner which assures continuity of care at reasonable costs for all residents of the area, and which is responsive to the needs and resources of the area. U.S. Code Cong. & Admin. News at p. 7887.

Further, the Committee indicated:

> A health planning agency is directed to seek to implement its long-range goal plan and short-term priorities plan with the assistance of individuals and public and private entities in its health area. In so doing, the agency is directed to provide technical assistance, to the extent practicable, to such entities in bringing about consistency with its health plan. Volume 4, U.S. Code Cong. & Admin. News at p. 7888.

This interpretation of the legislative history is further supported by Representative Paul Rogers in debates over subsequent amendments to this Act. Representative Rogers expressed concern over interpretations of the National Health Planning and Resource Development Act of 1974:

> Concern has been expressed that HSA's and health care providers who voluntarily carry out the mandates of the health planning laws (titles XV and XVI of the Public Health Service Act) may be in violation of the antitrust laws.
>
> The antitrust laws prohibit actions which have the effect of restraining trade or competition. We have found, however, that there is minimal price competition within some parts of the health sector and that often the only competition is around the provision of services. One undesirable result of service competition has been that hospitals and other health care providers have acquired duplicative and expensive equipment and facilities which have led to higher costs for the consumer. In enacting Public Law 93-641, which added titles XV and XVI to the Public Health Service Act, the Congress made a specific judgment that control of the development of health care facilities was needed even though price and service competition might

be restrained, and created a health planning system that could promote the efficient use of health resources through the regulation of and voluntary action by providers.

Title XV requires HSA's to bring together both consumers and providers to plan for an efficient health care system that will meet the area's needs. The HSA governing body is to make decisions in its health systems plan and in appropriateness [sic] review recommendations that affect market allocation .... In doing so, the HSA may develop institution-specific recommendations; ... or develop broader recommendations, such as, three cardiac catheterization laboratories in the area should be consolidated. In either case, it is congressional intent that providers and consumers work together in cooperation with the HSA to determine how best to carry out such recommendations. Without the voluntary cooperation of providers, the provision of title XV dealing with the development of a plan and the review of existing institutional health services could not be carried out.

... congressional intent was for the HSA, the congressional intent was for the HSA, the provider seeking the certificate of need and other providers which might seek to provide similar services to coordinate their activities to assure that new institutional health services are developed in accordance with the health systems plan for the area.

Although Public Law 93-641 contains no specific exemption from the antitrust laws, an analysis of the activities required of HSA's and

> providers indicates that Congress sanctioned actions which might otherwise be in violation of our antitrust laws. The intent of Congress was that HSA's and providers who voluntarily work with them in carrying out the HSA's statutory mandate should not be subject to the antitrust laws. If they were, Public Law 93-641 simply could not be implemented. Congressional Record House, No. 18 Part 1, p. H11962-H11963.

National Gerimedical Hospital & Gerontology Center v. *Blue Cross, supra,* 479 F. Supp. at 1021-23.

We adopt the district court's discussion, as set out above. We affirm the district court's holding; the doctrine of implied immunity applies to Blue Cross' voluntary cooperation with the congressionally designated HSA in requiring Hospital to obtain need approval from MAHSA prior to applying for a Blue Cross membership contract.

Appellee Blue Cross also argues that the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15, exempts the challenged conduct from the federal antitrust laws. We agree, in all respects, with the district court's holding that *Group Life & Health Insurance Co.* v. *Royal Drug Co., Inc.,* 440 U.S. 205 (1979) (defining "the business of insurance" in connection with the McCarran-Ferguson Act) controls. *National Gerimedical Hospital & Gerontology Center* v. *Blue Cross, supra,* 479 F. Supp. at 1016-19. Thus, we hold that the McCarran-Ferguson Act insurance exemption is not applicable in this case.

The district court is affirmed.

A true copy.

Attest:

CLERK, U.S. COURT OF APPEALS, EIGHTH CIRCUIT.

APPENDIX B

OPINION OF THE DISTRICT COURT

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IN THE
United States District Court
FOR THE WESTERN DISTRICT OF MISSOURI
WESTERN DIVISION

No. 78-0359-CV-W-3

NATIONAL GERIMEDICAL HOSPITAL
AND GERONTOLOGY CENTER,
Plaintiff,

VS.

BLUE CROSS OF KANSAS CITY, *et al.*,
Defendants.

Order

(filed November 2, 1979)

On May 23, 1978, plantiff, National Gerimedical Hospital and Gerontology Center (hereinafter referred to as National Gerimedical) filed a complaint against Blue Cross of Kansas City and Blue Cross Association alleging violations of the antitrust provisions of state and federal statutes.

Count I of the complaint alleges that the defendants and various named co-conspirators have engaged in a conspiracy in restraint of trade in violation of § 1 of the Sherman Act, 15 U.S.C. § 1. Plaintiff alleges in Count II that the defendants engaged in a continuing combination and conspiracy to boycott National Gerimedical in violation of § 1 of the Sherman Act, 15 U.S.C. § 1. Count III alleges that defendant Blue Cross Association and Blue Cross of Kansas City and their co-conspirators have combined and conspired in a continuous combination and conspiracy to boycott plaintiff hospital and coerce all Blue Cross subscribers to refuse to deal with plaintiff,

in violation of § 1 of the Sherman Act, 15 U.S.C. § 1. Count IV alleges that the defendants' actions were an effort to control market entry and dictate terms of access to the health care services market and constitute an unlawful abuse of monopoly power in violation of § 2 of the Sherman Act, 15 U.S.C. § 2. Counts V through VIII allege violations of similar provisions of the state antitrust laws, Missouri Revised Statutes § 416.031-1 through § 416.031-2.

On July 14, 1978, defendant Blue Cross Association and defendant Blue Cross of Kansas City filed motions to dismiss plaintiff's amended complaint. After considering the parties' suggestions in support and in opposition thereto, the Court refrained from deciding the issues raised by the motion to dismiss pending the Supreme Court's decision in *Group Life and Health Ins. Co.* v. *Royal Drug Co.* Subsequent to the Supreme Court decision in that case on February 27, 1979, the parties have briefed the issue of the application of that case to the present facts. The defendants base their motion to dismiss the federal causes of action on essentially four grounds: (1) The conduct complained of is exempted from the antitrust laws by the provisions of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015; (2) the National Health Planning & Resource Act of 1974 impliedly repealed the antitrust laws where the challenged conduct is necessary to effectuate the purpose of the Act; (3) plaintiff's complaint does not allege any ultimate facts to support a claim that the defendants engaged in a conspiracy within the meaning of the antitrust laws; and (4) prepaid medical plans offered by not-for-profit corporations are not "trade or commerce" within the meaning of the Sherman Act. Additionally, the defendants argue that if the federal claims are dismissed for lack of jurisdiction, the Court should exercise its discretion and dismiss the pendent state claims.

In an order issued October 11, 1979, this Court indicated that because it was considering matters outside the pleadings presented by the parties, it would treat the motion to dismiss as one for summary judgment in accordance with Rule 12(b)(6)

of the Federal Rules of Civil Procedure. The parties were given an opportunity to present additional evidence or to oppose this action. All parties have indicated that they have no further evidence to present and do not oppose this treatment by the Court.

Rule 56(c) provides in part that summary judgment should be granted when:

> ... the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.

It is well established that in considering a motion for summary judgment, the Court examines the evidence not to decide issues of fact but to determine if any real issues exist. *Krupin* v. *United States,* 439 F. Supp. 440 (E.D. Mo. 1977); *Bazzano* v. *Rockwell International Corp.,* 439 F. Supp. 1167 (E.D. Mo. 1977). The existence of some disputed facts in a case does not necessarily preclude the Court from granting summary judgment. To preclude summary judgment, the disputed facts must be material and of the type that would affect the outcome of the litigation. *Hahn* v. *Sargent,* 523 F.2d 461, 464 (1st Cir. 1975). Where legal questions of statutory construction involving legislative history and policy are concerned, summary judgment is an appropriate mechanism for disposing of these issues. *Mobil Oil Corp.* v. *Federal Energy Adm.,* 566 F.2d 87, 91-2 (T.E. App. 1977).

The Eighth Circuit has consistently recognized that summary judgment is an extreme remedy which should not be granted unless the movant establishes his right to judgment with such clarity as to leave no room for controversy. *Ledwith* v. *Douglas,* 77-1463, (January, 1978); *Unlaub Co.* v. *Sexton, Inc.,* 77-1293 (8th Cir. 1977).

In considering this motion the Court must view the facts most favorably to the party opposing the motion and give that

party the benefit of any reasonable inferences to be drawn from the facts. *Ledwith, supra; Unlaub, supra; New England Mutual Life Ins. Co.* v. *Null,* 554 F.2d 896, 906 (8th Cir. 1977). From all of the pleadings the Court has reviewed, it would appear that there is no material dispute as to the following facts which are a summary of the essential allegations of plaintiff's complaint by Blue Cross of Kansas City:

1. Plaintiff is a Missouri not-for-profit corporation which will open a *new* hospital on or about July 30, 1978 (Paragraph 3, Complaint);

2. Defendant Blue Cross of Kansas City is a Missouri not-for-profit Health Service corporation which offers private individual and group health care reimbursement plans and programs to the general public in Missouri and Kansas, and which contract with member hospitals and with other health service provides for the administration of its health care reimbursement plans (Paragraph 4, Complaint);

3. Blue Cross is a major provider of private health care plans in Western Missouri and Eastern Kansas (Paragraph 13, Complaint);

4. All acute general care hospitals except plaintiff in the Blue Cross service area have contracted with Blue Cross and thus are "participating" hospitals. (*Ibid.*);

5. Blue Cross reimburses its individual subscribers for 100% of all covered hospitals services, by direct payment to the hospital, for services at a participating hospital (*Ibid.*);

6. Blue Cross subscribers receive payment for 80% of covered hospital services performed at a non-participating hospital, which reimbursement is paid directly to the subscriber, not the hospital (*Ibid.*);

7. Blue Cross denied plaintiff a participating Member Contract solely because plaintiff failed to demonstrate a need for its hospital (Paragraph 17, Complaint);

8. Among the "Prerequisites" for membership in Blue Cross, was the requirement that a hospital "meet a clearly evident need for health care services in its defined service area." (Paragraph 18, Complaint);

9. In order to determine "clearly evident need" Blue Cross designated Mid-America Health Systems, Inc. ("MAHSA") a not-for-profit, non-governmental organization, engaged in the voluntary evaluation of health care services in Missouri and Kansas as the agency to conduct "need review" (Paragraphs 6 and 18(a), Complaint);

10. Blue Cross will not contract with any hospital as a "participating member hospital without MAHSA approval of need" (Paragraph 18(a), Complaint);

11. MAHSA has no power to impose sanction to enforce its determinations nor to compel review (Paragraph 18(b), Complaint);

12. MAHSA has publicly stated that it will disapprove and not consider favorably the addition of any acute care hospital beds.

Plaintiff's answers to interrogatories clarify one point. National Gerimedical Hospital's initial application to become a Blue Cross member hospital was made October 4, 1977 and was amended and resubmitted on February 15, 1978. (*See* Plaintiff's answer to Interrogatory No. 9, Ex. D.) On March 21, 1978 National Gerimedical Hospital was denied member status because it had not received approval through the voluntary health planning process. National Gerimedical has indicated that it never sought review by Mid-America Health Systems Agencies. (*See* Plaintiff's answer to defendant's interrogatory No. 16, Ex. F.) Thus this is not a situation where Mid-America Health Systems has refused to issue a certificate of need to National Gerimedical Hospital, but rather plaintiff is challenging the policy of Blue Cross requiring them to seek Mid-America Health Systems' approval.

Application of McCarran-Ferguson Act

§ 2 of the McCarran-Ferguson Act, 15 U.S.C. § 1012(a) and (b) provides in part:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, . . . *Provided,* That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

In essence this Act has been interpreted to exempt the application of the antitrust laws from the business of insurance if it is regulated by the state and if the challenged action does not involve a boycott, coercion or intimidation. In determining the initial applicability of the McCarran-Ferguson Act, two questions must be answered: (1) are the defendants engaged in "the business of insurance" and (2) is the challenged conduct regulated by state law? In order for the activity to be exempt from the application of the antitrust laws, both of the above criteria must be satisfied.

The briefs of Blue Cross of Kansas City and Blue Cross Association submitted in July of 1978 cited numerous case decisions holding that hospital-provider contracts are the business of insurance, regulated by state law, and thus exempt from application of the antitrust laws. Had the Court been deciding this issue prior to February 27, 1979, it would have adopted the rationale of these decisions and found that hospital payments

and subscriber rates were so interrelated that Blue Cross contracts with hospitals were a part of the business of insurance. Additionally, the Court would have found that the requirements of state regulation of the business of insurance had been met. However, the Court believes that in light of the language used by the Supreme Court in *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 59 L.Ed.2d 261 (1979) the rationale of these earlier circuit court opinions is no longer valid.

In Royal Drug eighteen owners of independent pharmacies sued Blue Shield of Texas. Blue Shield offers insurance policies on prescription drugs. If an individual covered by one of these policies utilizes a pharmacy which has entered into a "pharmacy agreement" with Blue Shield, the insured pays $2.00 and the remainder of the prescription price is paid by Blue Shield. If the pharmacy selected is a non-participating pharmacy and has not signed such an agreement with Blue Shield, the individual must pay the full price charged for the drug by the pharmacy. The insured can then obtain a reimbursement for 75% of the difference between the price charged minus $2.00. Under the agreement Blue Shield agreed to reimburse a participating pharmacy for the pharmacy's cost of acquiring the drug plus the $2.00 paid by the individual. Thus only pharmacies that could afford to distribute prescription drugs for less than the $2.00 markup could profitably participate in the plan. In determining if the contract between Blue Shield and the pharmacies was exempt from the application of the antitrust laws because of the McCarran-Ferguson Act, the Court identified one of the primary elements of an insurance contract as the spreading and underwriting of the policyholder's risk. Petitioners in the *Royal Drug* case argued that these pharmacy agreements did involve the underwriting of risk. Although the Court recognized that some type of provider agreement will be necessary for the existence of a service benefit plan, the Supreme Court was unwilling to infer that because an agreement is necessary to provide insurance, it is also "the business

of insurance." *Royal Drug, supra* at 270 ftn. 9. In rejecting this argument, the Court found:

> The fallacy of the petitioners' position is that they confuse the obligations of Blue Shield under its insurance policies, which insure against the risk that policyholders will be unable to pay for prescription drugs during the period of coverage, and the agreements between Blue Shield and the participating pharmacies, which serve only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations.
>
> * * *The Pharmacy Agreements thus do not involve any underwriting or spreading of risk, but are merely arrangements for the purchase of goods and services by Blue Shield. By agreeing with pharmacies on the maximum prices it will pay for drugs, Blue Shield effectively reduces the total amount it must pay to its policyholders. The agreements thus enable Blue Shield to minimize costs and maximize profits. Such cost savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the "business of insurance."
>
> The Pharmacy Agreements are thus legally indistinguishable from countless other business arrangements that may be made by insurance companies to keep their costs low and thereby also keep low the level of premiums charged to their policyholders. *Royal Drug, supra* at 269-270.

Another reason for rejecting the claim that these contracts involved the business of insurance was the fact that the contracts in the the *Royal Drug* case were not between insurer and insured but were separate contractual arrangements between Blue Shield and the pharmacies engaged in the sale and

distribution of goods and services other than insurance. The Court stated:

> At the most, the petitioners have demonstrated that the Pharmacy Agreements result in cost savings to Blue Shield which may be reflected in lower premiums if the cost savings are passed on to policyholders. But, in that sense, every business decision made by an insurance company has some impact on its reliability, its ratemaking, and its status as a reliable insurer. The manager of an insurance company is no different from the manager of any enterprise with the responsibility to minimize costs and maximize profits. If terms such as "reliability" and "status as a reliable insurer" were to be interpreted in the broad sense urged by the petitioners, almost every business decision of an insurance company could be included in the "business of insurance". Such a result would be plainly contrary to the statutory language, which exempts the "business of insurance" and not the "business of insurance companies." *Royal Drug, supra* at 271-272.

Defendants have attempted to distinguish the *Royal Drug* case on the grounds that the provider contract involved here contain the indispensable characteristic of insurance, *i.e.* the underwriting and spreading of risk. In support of this argument, the defendants suggest:

> Under the provider contract Blue Cross agrees to reimburse hospitals for services rendered to its subscribers *only so far as current earned income will permit.* (Article IVA, Provider Contract). Unless provisions for all expenses and allocations to reserves have been each month, earned income cannot be used to pay hospitals (Article IVC, IVD). If Blue Cross does not have sufficient funds to pay benefit payments in full to hospitals, each of the provider

> hospitals is to receive only a portion of the benefit payments on a pro rata basis from Blue Cross. [pp. 3-4, Reply of Blue Cross of Kansas City To Supplemental Suggestions of National Gerimedical Hospital in Opposition to Defendants' Separate Motions to Dismiss filed April 9, 1979.]

Were the Court to agree with defendants' interpretation of the contract, it is doubtful if *Royal Drug* would be sufficiently distinguished to render its holding inapplicable. However, the Court's interpretation of the provider contract in this case is not totally in accord with the defendants. Article IVB does require reserves to be maintained by Blue Cross sufficient to provide for three months operating expenses and benefits for hospital services. After provisions for reserves have been made, benefit payments each month are to be made to the hospitals equal to the amount of benefits due for all claims processed by Blue Cross. If sufficient funds are not available, adjustment on a pro rata basis is to be made; however, Article 4D provides:

> D. If benefit payments to HOSPITAL for Hospital Service are reduced because of the application of Article IV, C above, BLUE CROSS agrees to pay pro rata the amount of such reduction to all hospitals as current earned income becomes available for such purpose.

Thus, the risk of nonpayment does not fall on the hospital as the defendants suggest, but payment is eventually to be made as funds become available on a pro rata basis.

Comparison of the Blue Cross provider contracts in this case and the Blue Shield pharmacy agreements in *Royal* have convinced the Court that no rational basis for distinguishing these contracts exist. Further, the language of the Supreme Court seems to clearly imply that such distinctions should not be drawn and would be looked on with disfavor.

> If agreements between an insurer and retail pharmacists are the "business of insurance," because

> they reduce the insurer's costs, then so are all other agreements insurers may make to keep their costs under control—whether with automobile body repair shops or landlords. Such agreements would be exempt from the antitrust laws if Congress had extended the coverage of the McCarran-Ferguson Act to the "business of insurance companies". But that is precisely what Congress did not do. *Royal Drug, supra* at 281.

The Supreme Court went on to add:

> There is no principled basis upon which a line could rationally be drawn that would extend the McCarran-Ferguson Act exemption only to an insurer's agreement with providers of goods and services to be furnished to its policyholders—such as agreements with hospitals, doctors, lawyers and the like. But assuming that such a line could rationally be drawn, to hold that even such provider agreements are the "business of insurance" is to ignore the language and purpose of the Act not to exempt the insurance industry as such from the antitrust laws. *Royal Drug, supra* at 281.

Therefore, defendants' motions for summary judgment on the basis that the conduct in this case involved "the business of insurance" and is thus exempt from the antitrust laws under the McCarran-Ferguson Act must be denied.

Implied Repeal of The Antitrust Laws

Secondly, the defendants have moved to dismiss the federal causes of action on the grounds that the National Health Planning and Resource Development Act of 1974 impliedly repealed application of the federal antitrust laws in the instant case. The doctrine of implied immunity or implied repeal of the antitrust laws is a judicially created exemption

from the application of the antitrust laws which has been utilized to resolve potential conflicts between federal or state regulatory schemes and the antitrust laws. The Supreme Court has indicated that implied immunity has been adopted and applied:

> [I]mplied immunity [has been found] in particular and discrete instances to assure that the *federal agency* entrusted with regulation in the public interest could carry out that responsibility free from the disruption of conflicting judgments that might be voiced by courts exercising jurisdiction under the antitrust laws.

A number of well established principles can be derived from cases that have considered this doctrine. First, any immunity from the antitrust laws should not be lightly implied and repeal by implication is not favored. *Gordon* v. *New York Stock Exchange,* 422 U.S. 659, 95 S.Ct. 2598, 45 L.Ed.2d 463 (1975); *U.S.* v. *American Telephone & Telegraph Co.,* 427 F. Supp. 57 (E.D. La. 1976). In considering a claim of implied repeal of the antitrust laws, the Court should first attempt to reconcile the operation of the antitrust laws and the regulatory statutes. *Essential Communication* v. *American Telephone & Telegraph,* 446 F. Supp. 1090 (D.N.J. 1978). If reconciliation is not possible, for the reason that a clear repugnancy exists between the statutes or the particular provisions at issue and the antitrust laws, then an exemption may be created; however, the antitrust laws should be repealed only to the extent necessary to make the regulatory statute effective and then only to the minimum extent needed. *Gordon, supra* at 479. *Mount Hood Stages* v. *Greyhound,* 555 F.2d 687 (9th Cir. 1977); *Oahu Gas Service, Inc.* v. *Pacific Resources, Inc.,* 460 F. Supp. 1359 (D. Ha. 1978); *Cavanagh Communities Corp.* v. *New York Stock Exchange,* 422 F. Supp. 385 (S.D.N.Y. 1976); see Application of Federal Antitrust Laws as Affected by Other Federal Statutes or the Federal Constitution, Annotation 45 L.Ed.2d 841.

After determining a conflict exists, the Court must also consider the manner in which Congress envisioned the conflict to be resolved. Therefore, the Court is faced with two issues in determining the effect of the National Health Planning and Resource Development Act of 1974. First, is there a conflict between this legislation and the antitrust laws. Secondly, how should that conflict be resolved.

In resolving the first issue, the Court must examine the 1974 National Health Planning and Resource Development Act. This Act was essentially composed of four parts: First, National Health Planning and Development, 42 U.S.C. § 300k through 300n-5; second, assistance for construction and modernization of health facilities; third miscellaneous provisions on the transition to the new program; and fourth, the Radiation, Health & Safety Act of 1974 amending the Public Health Service Act in this area. *See* Volume 4, U.S. Code Cong. & Adm. News (1977) p. 7842. The only portion of the Act with which the Court is concerned in this case is Subchapter XIII entitled "National Health Planning and Development".

The National Health Planning and Development portion of the Act established national health priorities. The Secretary of HEW was directed to issue guidelines concerning national health planning goals after considering the national health priorities established by Congress in this section of the Act. Two goals that were established by the Act and of special concern to Congress as evidenced in the Act and in its accompanying legislative history were: (1) reduction of hospital costs; and (2) elimination of unnecessary duplication of health care facilities. The Secretary was also directed to set standards concerning the appropriate supply, distribution and organization of the nation's health resources. *See* 42 U.S.C. §300k-1 through 300k-2. The National Advisory Council on health planning and development was established to advise and consult with HEW and to make recommendations to that department concerning the development of appropriate guidelines. 42 U.S.C. §300k-3.

The Act provided for the establishment of health service areas in accordance with a number of very specific requirements set forth in 42 U.S.C. § 300*l*. To service these areas, health systems agencies were to be established in each health system area. These agencies were given responsibility for health planning and resource development in their particular area. 42 U.S.C. § 300*l*-2(b). Each health systems agency was to adopt a health service plan and an annual implementation plan. The functions assigned to the health service area were to effectuate the purposes of: (1) improving the health of the residents of their area; (2) increasing accessibility, acceptability and quality of the health services provided in their area; (3) restraining increases in the cost of health care; and (4) preventing unnecessary duplication of health resources. 42 U.S.C. §300*l*-2. Procedures were also established for a state health planning and development program. The Act further provided that to implement the health service plan and the annual implementation plan, the Health Service Agency should seek the assistance of individuals, public and private entities, in its health service area. *See* 42 U.S.C. § 300*l*-2(c)(1). It thus appears that the Act authorized and anticipated that the health service agency established by its provisions would consult and work with private health care providers to attempt to achieve voluntary cooperation with the goals of the agency and of the Act.

Mid-America Health Systems Agency was one of 205 regional health systems agencies established under the Act and conditionally designated as the health planning body for the eight county bi-state area encompassing the counties of Cass, Clay, Jackson, Platte and Ray in Missouri and Johnson, Levenworth and Wyandotte in Kansas. In November of 1977 Mid-America Health Systems established a health systems plan for 1978 through 1982 in this region. Increasing hospital costs and unnecessary duplication of facilities and equipment were considered two of the biggest problems in this region. The

health systems plan adopted by Mid-America Health Systems recognized:

> Problem—The acute inpatient care system does not function in a coordinated manner which is cost-effective in the delivery of acute care services at the most appropriate level consistent with quality standards. (Health Systems Plan at p. 6-19.)

The goal in this area was recognized as:

> **Goal:** Improve the health of the population in the MAHSA area through an adequately available and accessible acute inpatient care system coordinated in a manner that fosters containment of health care costs and provides quality of care in a culturally acceptable manner. (Health Systems Plan at p. 6-19.)

To implement this goal MAHSA established a number of objectives in this area and specified particular methods that could be utilized to achieve each objective. Objective No. 4 seeks to:

> **Objective #4**
> Maintain a rate of increase in total expenditures for hospital care services which does not exceed the rate of increase in the medical care services component of the Consumer Price Index. (Health Systems Plan at p. 6-21.)

As one of the nine methods set forth to meet this goal, Mid-America Health System suggested:

> (6) Third party payors and the hospital community should work together to develop uniform reporting systems and procedures such that meaningful hospital-to-hospital and year-to-year hospital cost and service-by-service utilization comparisons can be made. (Health Systems Plan at p. 6-22.)

The certificate of need requirement voluntarily adopted by Blue Cross of Kansas City seems to be authorized by the Act as well as the implementation plan of MAHSA.

In determining if an exemption to the antitrust laws can be implied, courts have distinguished two types of exemptions—specific and blanket. A specific repeal of the antitrust laws implies an exemption only for particular conduct or activity. An exemption for an entire legislative scheme would be a blanket exemption. Courts that have upheld claims of implied repeal have normally limited this repeal to the specific conduct challenged in that particular case; however, in the circumstances of this case defendant's claim is that the entire concept of the National Health Planning and Resource Development Act presupposes nonapplication of the antitrust laws so that any activity authorized and within the scope of that Act is free from antitrust challenges. The proper issue in this case then is whether there is a plain repugnancy between the scope of the National Health Care Planning and Development Act and the antitrust laws. Another formulation of this same test of somewhat easier application is whether an exemption to the antitrust laws is necessary to make this statutory scheme effective. The Court believes the answer is yes. In the Court's view, voluntary cooperation of the entire health care industry, including third party payors, is essential to the success of the Act.

The National Health Planning and Resource Development Act clearly attempted to set forth health care goals and a regional administrative framework within which achievement of these goals could be sought through cooperation and voluntary compliance with the health care industry. If the Court were to find that private business working in conjunction with the health system agency established by the Act in their area to achieve the goals of the Act were liable or might be liable under the antitrust law for their action, then the Court believes that the accomplishment of the purpose of the goals of the Act would be effectively foreclosed.

Having determined that a conflict exists, the Court must consider the method for resolving the discrepancy. The entire concept of the Act as well as the legislative history convinces the Court that the antitrust laws were not intended to apply to members of the health care industry clearly acting within the scope of the Act. In essence the antitrust laws posit that the public interest will be served best when business enterprises are compelled to compete in markets free of anti-competitive restraints. *See Essential Communities* v. *American Telephone & Telegraph,* 446 F. Supp. 1090 (D.N.J. 1978). The concern of the Senate Committee that considered the health care legislation at issue here was the failure of the health care industry to "respond to classic marketplace forces." *See* Volume 4, U.S. Code Cong. & Adm. News at p. 7878. In the Committee's view:

> The highly technical nature of medical services together with the growth of third party reimbursement mechanisms act to attentuate the usual forces influencing the behavior of consumers with respect to personal health services. For the most part, the doctor makes purchasing decisions on behalf of the patient and the services are frequently reimbursed under health insurance progams, thus reducing the patient's immediate incentive to contain expenditures. Volume 4, U.S. Code Cong. & Adm. News at p. 7878.

The Committee expressed concern over increasing hospital costs and improper utilization of existing facilities. Volume 4, U.S. Code Cong. & Adm. News at pp. 7893-4. The Committee in fact stated:

> The recent rapid acceleration in the costs of personal health services, far outstripping the rate of inflation in other sectors of the economy, has caused the Committee great concern. Although recognizing the increase in costs experienced by health care providers

> attributable to general inflation, the Committee wishes to express its concern with respect to the disproportionately high rate of increase in costs of health care services. Volume 4, U.S. Code Cong. & Adm. News at p. 7895.

The Committee attributed many of the cost and duplication problems in the health care industry to reimbursement programs like the ones these defendants sponsor. The legislative history indicates to this Court that any attempts by companies such as these defendants to reduce costs and duplication were to be welcomed and were considered essential to a successful program of cost reduction. In summarizing the Act, the Committee stressed:

> The long-range goal plan is expected to provide for the prevention of unnecessary duplication of resources and assure that quality health services will be available and accessible in a manner which assures continuity of care at reasonable costs for all residents of the area, and which is responsive to the needs and resources of the area. U.S. Code Cong. & Adm. News, at p. 7887.

Further, the Committee indicated:

> A health planning agency is directed to seek to implement its long-range goal plan and short-term priorities plan with the assistance of individuals and public and private entities in its health area. In so doing, the agency is directed to provide technical assistance, to the extent practicable, to such entities in bringing about consistency with its health plan. Volume 4, U.S. Code Cong. & Adm. News at p. 7888.

This interpretation of the legislative history is further supported by Representative Paul Rogers in debates over subsequent amendments to this Act. Representative Rogers

expressed concern over interpretations of the National Health Planning and Resource Development Act of 1974:

> Concern has been expressed that HSA's and health care providers who voluntarily carry out the mandates of the health planning laws (titles XV and XVI of the Public Health Service Act) may be in violation of the antitrust laws.
>
> The antitrust laws prohibit actions which have the effect of restraining trade or competition. We have found, however, that there is minimal price competition within some parts of the health sector and that often the only competition is around the provision of services. One undesirable result of service competition has been that hospitals and other health care providers have acquired duplicative and expensive equipment and facilities which have led to higher costs for the consumer. In enacting Public Law 93-641, which added titles XV and XVI to the Public Health Service Act, the Congress made a specific judgment that control of the development of health care facilities was needed even though price and service competition might be restrained, and created a health planning system that could promote the efficient use of health resources through the regulation of and voluntary action by providers.
>
> Title XV requires HSA's to bring together both consumers and providers to plan for an efficient health care system that will meet the area's needs. The HSA governing body is to make decisions in its health systems plan and in appropriateness [sic] review recommendations that affect market allocation. . . In doing so, the HSA may develop institution-specific recommendations; . . . or develop broader recommendations, such as, three cardiac catheterization laboratories in the area should be

> consolidated. In either case, it is congressional intent that providers and consumers work together in cooperation with the HSA to determine how best to carry out such recommendations. Without the voluntary cooperation of providers, the provision of title XV dealing with the development of a plan and the review of existing institutional health services could not be carried out.
>
> . . . congressional intent was for the HSA, the provider seeking the certificate of need and other providers which might seek to provide similar services to coordinate their activities to assure that new institutional health services are developed in accordance with the health systems plan for the area.
>
> Although Public Law 93-641 contains no specific exemption from the antitrust laws, an analysis of the activities required of HSA's and providers indicates that Congress sanctioned actions which might otherwise be in violation of our antitrust laws. The intent of Congress was that HSA's and providers who voluntarily work with them in carrying out the HSA's statutory mandate should not be subject to the antitrust laws. If they were, Public Law 93-641 simply could not be implemented. Congressional Record—House, No. 18 Part 1, p. H11962–H11963.

A review of the Act and its legislative history compels this Court to concur with Representative Rogers' analysis of congressional intent in enacting the National Health Planning and Resource Development Act. It should be noted that congressional failure to include specific antitrust exemptions for the activities challenged in this case may in part be accounted for by the status of the case law in 1974. The majority of courts confronted with the issue at that time had held that third party reimbursement contracts came within already existing statutory exemptions under the McCarran-Ferguson Act. The fact that this ex-

emption no longer applies in the instant case does not detract from the clear Congressional intent that activities in the health care area to reduce cost and eliminate duplication would not be subject to challenge under the antitrust statutes.

The defendants in support of their claim of implied repeal cite the March 2, 1979 decision of the United States District Court for the Eastern District of Michigan in *Port Huron Valley Hospital, Inc.* v. *City of Pontiac, et al.,* (attached as Exhibit C to the brief of Blue Cross of Kansas City filed April 9, 1979). A review of Judge Kennedy's opinion in *Port Huron* reveals that the existence of circumstances not present in this case were crucial to the reasoning and outcome there. In *Port Huron* the State of Michigan had adopted certificate of need legislation. Although such legislation is contemplated by the provisions of the National Health Care Planning and Research Development Act, *see* 42 U.S.C. 300m1-5, Judge Kennedy's decision relied on the potential conflict between the state regulation and the federal antitrust laws. The Court does not view *Port Huron* as precedent for its decision in this case. However, it recongizes that the creation of an exemption from the antitrust laws where state certificate of need legislation is passed to insure compliance with the federal act and application of the antitrust laws in instances of voluntary compliance with the federal act would be anomalous. Although not essential to the decision, the Court in *Port Huron* did find that the legislative history of the National Health Care Planning & Resource Development Act demonstrated congressional intent to at least partially repeal the antitrust laws. In fact Judge Kennedy found that it was the purpose of the Act to check the competition of the free market in the health services area. The Court would concur in this assessment of the Act.

On the basis of the factors outlined above, the Court finds: (1) a clear repugnancy exists between the National Health Care Planning & Resource Development Act and the antitrust laws; (2) Congress intended that action taken pursuant to the Act and clearly within the scope of the Act would be exempt from application of the antitrust laws. Therefore, the defendants' motion for summary judgment Counts I through IV on the

grounds that the challenged conduct is exempt from the antitrust laws will be granted.

Two other issues were raised by the defendants which the Court will briefly discuss.

FAILURE TO STATE A CONSPIRACY CLAIM

Defendants characterize the statements concerning the conspiracy as conclusionary and maintain that these allegations are not supported by any allegations of material fact. To maintain a cause of action under § 1 of the Sherman Act a party must set forth the following allegations:

> (1) That the defendants contracted, combined, or conspired among each other; (2) that the combination or conspiracy produced adverse, anti-competitive effects within relevant product and geographic markets; (3) that the objects of and the conduct pursuant to that contract or conspiracy were illegal; and (4) that the plaintiff was injured as a proximate result of that conspiracy. *Martin B. Glauser Dodge Co.* v. *Chrysler Corp.*, 570 F.2d 72, 81 (3rd Cir. 1977).

The Eighth Circuit has emphasized that the complaint need not set forth specific facts to support its general allegations. *Great Atl. & Pac. Tea Co.* v. *Amalgamated Meat Cutters & Butchers Workmen of North American Local No. 88,* 410 F.2d 650, 652 (8th Cir. 1969). The Court finds that judged by these standards the conspiracy allegations are sufficiently detailed to meet the above requirements and the complaint is not subject to dismissal for failure to allege ultimate facts supporting this theory.

The defendants also argued that sufficient facts are not alleged to demonstrate a boycott within the meaning of § 2(b) of the McCarran-Ferguson Act. Even if the business of

insurance regulated by the state is involved so that generally the antitrust laws are inapplicable to a particular activity, an exception to this general rule is created by § 2(b) of the McCarran-Ferguson Act for concerted activity constituting a boycott, coercion or intimidation. Defendants had argued that even if the Court found that the business of insurance regulated by the state was involved, this exception mandated application of the antitrust laws. The issue of whether plaintiff has alleged sufficient facts to demonstrate that the boycott provisions of § 2(b) apply need not be reached since the Court finds that the exemption of the McCarran-Ferguson Act for the business of insurance does not apply.

INTERSTATE COMMERCE REQUIREMENT

Finally the defendants have moved to dismiss the complaint on the grounds that prepaid medical plans offered by not-for-profit corporations are not trade or commerce within the meaning of the Sherman Act. Section 1 of the Sherman Act provides in part:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. . .

Restraint of trade or commerce is within the prohibition of the commerce requirement only if that restraint affects trade or commerce among the several states or with foreign nations. This effect on commerce requirement is therefore jurisdictional in nature and may be demonstrated in one of two ways. One formulation of the commerce requirement is the "flow of commerce" or qualitative test wherein the restraint complained of is placed directly on goods or services which are themselves in the flow of interstate commerce. Secondly, the requisite commerce requirement may be demonstrated by a quantitative test which involves transactions that although wholly intrastate

substantially affect the flow of interstate commerce. *See* Von Kalinowski, 1 Antitrust Laws and Trade Regulations § 501[1]-[3].

Plaintiffs allegations appear to fall under the latter theory. Paragraph 15 of plaintiff's complaint states that National Gerimedical is one of the first hospitals in the United States specializing in health care services for the elderly. As such, it is intended to serve a national constituency through research and the development of improved health care for the aged. Involvement and effect on interstate commerce is alleged to exist because National Gerimedical is intended to service out of state patients, purchase drugs and supplies from out of state sources, receive income and make disbursements from out of state insurance, and receive out of state financing for construction and operation. Plaintiff's complaint further indicates that Blue Cross's denial of participating status will foreclose to plaintiff a significant portion of the health care market thus affecting the services rendered to out of state patients, the ability to purchase from out of state sources, and the utilization of out of state financing and insurance proceeds. While these allegations are not as specific as might be desired, the Court finds that this issue is controlled by the decision in *Hospital Building Co.* v. *Trustees of Rex Hospital,* 425 U.S. 738, 96 S.Ct. 1848, 48 L.Ed.2d 338 (1976). In Trustees of Rex Hospital plaintiff contended that defendant, a competing hospital, had conspired to restrain plaintiff's planned expansion of facilities in violation of § 1 and § 2 of the Sherman Act. Although the only contended effects on interstate commerce stemmed from plaintiff's provision of intrastate hospital services, the Court concluded that a substantial effect on interstate commerce had been alleged. The Court ruled:

> The complaint, fairly read, alleges that if respondents and their coconspirators were to succeed in blocking petitioner's planned expansion, petitioner's purchases of out-of-state medicines and supplies as well as its revenues from out-of-state insurance companies

> would be thousands and perhaps hundreds of thousands of dollars less than they would otherwise be. Similarly, the management fees that petitioner pays to its out-of-state parent corporation would be less if the expansion were blocked. Moreover, the multimillion-dollar financing for the expansion, a large portion of which would be from out of State, would simply not take place if the respondents succeeded in their alleged scheme. This combination of factors is certainly sufficient to establish a "substantial effect" on interstate commerce under the Act. *Trustees of Rex Hospital, supra* at 343-4.

In reaching this decision the Court rejected an argument that the conduct is outside the scope of the Sherman Act because the effect on commerce is indirect and the conduct producing the effect not purposefully directed toward interstate commerce. Additionally, the Court found that an effect on commerce may be substantial under the Sherman Act even if its impact on interstate commerce falls far short of causing enterprises to fold or affecting market prices. In the final analysis, allegations that:

> . . . fairly claim that the alleged conspiracy, to the extent it is successful, will place "unreasonable burdens on the free and uninterrupted flow" of interstate commerce, they are wholly adequate to state a claim. *Trustees of Rex Hospital, supra* at 345.

Defendants argue that prepaid medical plans are not trade or commerce and rely on *United States* v. *Oregon State Medical Society,* 343 U.S. 326, 72 S.Ct. 690, 96 L.Ed.2d 978 (1951). In the Court's view, *Oregon State Medical Society* is not controlling the instant case. In *Oregon State Medical Society* it was alleged that the state medical association and local medical organizations had agreed not to compete in particular areas in offering their prepaid medical plans. The Court found that the sale of medical services through these prepaid plans was not trade or

commerce. The challenged conduct here involves contracts or potential contracts between Blue Cross and the supplier of actual hospital services. Plaintiff's claim that the action complained of will affect the ability of National Gerimedical to provide the desired hospital services is indistinguishable from the effect that plaintiff's action was alleged to have caused in *Trustees of Rex Hospital.*

For the above reasons, the Court believes the allegations of the complaint establish that failure to obtain status as a "participating hospital" will have an effect on interstate commerce. Therefore, the defendants' motions for summary judgment on the grounds that the requisite effect on trade or commerce has not been alleged will be denied.

PENDENT STATE CLAIMS

Having determined that dismissal of Counts I through IV is appropriate, the Court must decide whether to retain the pendent state claims encompassed in Counts V through VIII. The Court recognizes that it has the power to decide the state claims. The issue is one of discretion. In *United Mine Workers* v. *Gibbs,* 383 U.S. 715, 86 S.Ct. 1130, 16 L.Ed.2d 218 (1966), the Surpreme Court wrote:

> It has consistently been recognized that pendent jurisdiction is a doctrine of discretion, not of plaintiff's right. Its justification lies in considerations of judicial economy, convenience and fairness to litigants; if these are not present a federal court should hesitate to exercise jurisdiction over state claims, even though bound to apply state law to them. . . . Needless decisions of state law should be avoided both as a matter of comity and to promote justice between the parties, by procuring for them a surer-footed reading of applicable law. Certainly, if the federal claims are dismissed before trial, even though

not insubstantial in a jurisdictional sense, the state claims should be dismissed as well.

Gibbs seemed to mandate dismissal of state claims where the federal claims were dismissed prior to trial. However, this aspect of *Gibbs* has been relaxed by subsequent Supreme Court cases. *See Rosado* v. *Wyman,* 397 U.S. 397, 90 S.Ct. 1207, 25 L.Ed.2d 442, 450-1 (1970).

Considerations of judicial economy, convenience and fairness to the litigants should be the determinative factors in deciding whether the Court should exercise its pendent jurisdiction or dismiss the State claims. *See Gibbs, supra; Rosado, supra; Blake* v. *Town of Delaware City,* 441 F. Supp. 1189, 1204-5 (D. Del. 1977). If hearings have been held in a case pending before the Court, discovery conducted and substantial work done towards preparing the action for trial, judicial economy might dictate retaining jurisdiction over the state claims. In this case however, no extensive discovery has been conducted on any issue other than the motion to dismiss and pending a ruling on the motion to dismiss, no answer has even been filed. Further, the issues researched and briefed by the parties involve federal claims and no issues under the state claims have yet been addressed by the parties or the court; thus, judicial economy does not mandate the retention of the state law claims in this instance. Further, this is not a case where dismissal of the parties will leave the plaintiff without an adequate state forum. Therefore, fairness does not mandate retention in this case. Additionally, the factual situation set forth in plaintiff's complaint may involve unique applications of the state antitrust laws. The Court believes that state courts should be allowed to consider issues involving state antitrust laws which will undoubtedly be raised for the first time by this case. It is a well established principle that needless decisions of state law should be avoided as a matter of comity and to procure for the parties "a surefooted reading of applicable law." *See Gibbs, supra;* and *Euster* v. *Pennsylvania State Horseracing Commission,* 431 F. Supp. 828 (E.D. Pa. 1977).

For the above reasons, the Court believes that a proper exercise of its discretion necessitates dismissal of the pendent state claims.

For all of the reasons outlined above, it is hereby

ORDERED that defendants' motion to dismiss which has been treated as a motion for summary judgment is hereby granted and summary judgment is entered in favor of defendants and against plaintiff on Counts I through IV of plaintiff's complaint; and it is futher

ORDERED that in the exercise of its discretion, the pendent state claims set forth in Counts V through VIII are also dismissed without prejudice.

.....

RUSSELL G. CLARK, Judge
United States District Court

Dated: November 2, 1979

APPENDIX C

JUDGMENT OF THE COURT OF APPEALS

JUDGMENT

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 79-2018

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER
Appellant,

v.

BLUE CROSS OF KANSAS CITY, BLUE CROSS ASSOCIATION,
Appellees.

APPEAL FROM the United States District Court for the Western District of Missouri.

THIS CAUSE came on to be heard on the original designated record of the United States District Court for the Western District of Missouri and briefs of the respective parties and was argued by counsel.

ON CONSIDERATION WHEREOF, it is now here ordered and adjudged by this Court, that the judgment of the said District Court, in this cause, be, and the same is hereby, affirmed in accordance with the opinion of this Court.

July 22, 1980

Costs taxed in favor of Appellee, Blue Cross Assn:	
Costs of printing 10 copies of brief:	$726.34
Total costs of Appellee, Blue Cross Assn., for recovery from Appellant in the U.S. District Court:.....	$726.34

A true copy

ATTEST: ROBERT D. ST. VRAIN
Clerk, U.S. Court of Appeals, 8th Circuit

APPENDIX D

ORDER DENYING PETITION FOR REHEARING

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United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 79-2018

NATIONAL GERIMEDICAL HOSPITAL
AND GERONTOLOGY CENTER,
Appellant,

vs.

BLUE CROSS OF KANSAS CITY, et al.,
Appellee.

ORDER

The Court, having considered appellant's petition for rehearing and suggestions for rehearing *en banc* and being now fully advised in the premises, hereby orders the petition for rehearing and suggestions for rehearing *en banc* denied.

August 22, 1980

FILED
MAR 12 1981
ALEXANDER L. STEVAS, CLERK

No. 80-802

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER,
Petitioner,

v.

BLUE CROSS OF KANSAS CITY, AND BLUE CROSS ASSOCIATION,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

JOINT APPENDIX

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PRESS OF BYRON S. ADAMS PRINTING, INC., WASHINGTON, D. C.

Petition for Certiorari Filed November 18, 1980.
Certiorari Granted January 26, 1981.

TABLE OF CONTENTS

	Page
Chronological List of Relevant Docket Entries	1a
Complaint (filed May 23, 1978)	5a
Motion of Blue Cross Association to Dismiss (filed July 14, 1978)	19a
Motion of Blue Cross of Kansas City to Dismiss (filed July 14, 1978)	21a
Affidavit of Donald L. Flora, Attachment to the Motion of Blue Cross Association to Dismiss and Suggestions of Blue Cross Association in Support of Motion to Dismiss (filed July 14, 1978)	25a
Excerpts from the MAHSA Systems Plan, Exhibit A to the Affidavit of Donald L. Flora (filed July 14, 1978)	27a
Affidavit of Jerry B. Buxton, Exhibit A to Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss (filed Aug. 18, 1978)	135a
Affidavit of Henry Mandro, Exhibit B to Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss (filed Aug. 18, 1978)	139a
Prerequisites for Application for Admission as a Blue Cross Participating Hospital, Exhibit C to Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss (filed Aug. 18, 1978)	141a
Newsletter from Blue Cross of Kansas City, Exhibit D to Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss (filed Aug. 18, 1978)	147a
Approval Program for Blue Cross Plans, Exhibit B to Answers of Blue Cross Association to Interrogatories of National Gerimedical Hospital (filed Nov. 28, 1978)	149a

Page

Cost Containment Approval Standard for Blue Cross Plans and Implementing Requirements and Guidelines, Exhibit F to Answers of Blue Cross Association to Interrogatories of National Gerimedical Hospital (filed Nov. 28, 1978) 159a

Affidavit of David J. Maschger, Exhibit J to Response of National Gerimedical Hospital to Order to Show Cause and Preliminary Suggestions of National Gerimedical Hospital Opposing Summary Judgment (filed Oct. 22, 1979) 167a

Letter from Gary L. Ihde to National Gerimedical Hospital, Exhibit K to Response of National Gerimedical Hospital to Order to Show Cause and Preliminary Suggestions Opposing Summary Judgment (filed Oct. 22, 1979) 169a

Order of the District Court for the Western District of Missouri (entered Nov. 2, 1979) 171a

Opinion of the United States Court of Appeals for the Eighth Circuit (entered July 22, 1980) 199a

Judgment of the United States Court of Appeals for the Eighth Circuit (entered July 22, 1980) 215a

Order denying Petition of National Gerimedical Hospital for Rehearing (entered Aug. 22, 1980) ... 217a

JOINT APPENDIX

Chronological List of Relevant Docket Entries

1978

May 23—Complaint of National Gerimedical Hospital filed.

July 14—Motion of Blue Cross Association to Dismiss filed. Motion of Blue Cross of Kansas City to Dismiss, with exhibits, filed.

Aug. 18—Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss, with exhibits, filed.

Sept. 8—Response of Blue Cross of Kansas City to Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss filed.

Oct. 6—First Interrogatories of National Gerimedical Hospital to Blue Cross Association and Blue Cross of Kansas City filed.

Nov. 28—Answers and Objections of Blue Cross Association to First Interrogatories of National Gerimedical Hospital filed.

Dec. 1—First Interrogatories of Blue Cross of Kansas City to National Gerimedical Hospital filed.

Dec. 21—Answers of Blue Cross of Kansas City to First Interrogatories of National Gerimedical Hospital, with exhibits, filed.

1979

Jan. 15—Answers of National Gerimedical Hospital to First Interrogatories of Blue Cross of Kansas City filed.

Mar. 7—Supplemental Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss filed.

Apr. 9—Reply of Blue Cross Association to Supplemental Suggestions of National Gerimedical Hospital in Op-

position to Motions to Dismiss filed. Reply of Blue Cross of Kansas City to Supplemental Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss, with exhibits, filed.

Apr. 23—Second Supplemental Suggestions of National Gerimedical Hospital Opposing Motions to Dismiss filed.

Oct. 11—Order to Show Cause Why Motion to Dismiss Should Not be Treated as One for Summary Judgment entered.

Oct. 22—Response of National Gerimedical Hospital to Order to Show Cause and Preliminary Suggestions Opposing Summary Judgment filed.

Oct. 24—Response of Blue Cross of Kansas City to Order to Show Cause and Reply to Preliminary Response of National Gerimedical Hospital filed.

Nov. 2—Order Granting Summary Judgment for Blue Cross Association and Blue Cross of Kansas City entered.

Nov. 30—Notice of Appeal filed.

Dec. 3—Appeal docketed.

1980

Jan. 29—Brief of National Gerimedical Hospital and Authorities Supplemental to Brief filed.

Jan. 30—Amicus Curiae Brief of Federation of American Hospitals filed.

Feb. 28—Brief of Blue Cross of Kansas City filed.

Feb. 29—Brief of Blue Cross Association filed.

Mar. 26—Brief of Amicus Curiae American Health Planning Association filed.

Mar. 28—Reply Brief of National Gerimedical Hospital filed.

Apr. 15—Oral Argument.

July 22—Opinion and Judgment of the United States Court of Appeals for the Eighth Circuit affirming Judgment of the District Court for the Western District of Missouri entered.

Aug. 15—Petition of National Gerimedical Hospital for Rehearing With Suggestions for Rehearing En Banc filed.

Aug. 22—Petition of National Gerimedical Hospital for Rehearing denied.

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF MISSOURI, WESTERN DIVISION

Case No. 78-0359-CV-W3

JURY DEMANDED

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER,
A Missouri Not-for-Profit Corporation,
530 North Murray,
Lee's Summit, Missouri 64063,
Plaintiff,

VS.

BLUE CROSS OF KANSAS CITY,
A Missouri Corporation,
3637 Broadway,
Kansas City, Missouri 64111,

Serve: Courtney H. Taber,
Registered Agent

and

BLUE CROSS ASSOCIATION,
An Illinois Corporation,
233 North Michigan Avenue,
Chicago, Illinois 60601

Serve: S. Martin Hickman,
President
Defendants.

COMPLAINT

(Filed May 23, 1978)

COMES NOW plaintiff, NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER and for its Complaint against

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BLUE CROSS OF KANSAS CITY and BLUE CROSS ASSOCIATION, defendants, states and shows to the Court as follows:

Jurisdiction and Venue

1. This is a civil antitrust action against defendants pursuant to Sections 4 and 16 of the Clayton Act [15 U.S.C. §§ 15 and 26] and Section 416.121, RSMo. (1975 Supp.) of the Missouri Antitrust Law for treble damages and injunctive relief. This Court has original jurisdiction hereof pursuant to 28 U.S.C. § 1337 and pendent jurisdiction of state law claims herein.

2. The unlawful acts and violations hereinafter alleged have been and are in part conceived, performed, carried out and made effective by defendants and others not now named as parties defendant in the Western District of Missouri, Western Division. The interstate trade and commerce hereinafter described is conducted in part within the Western District of Missouri, Western Division by all parties hereto. Each defendant named herein conducts and transacts business in the Western District of Missouri, Western Division. Venue is proper in this Court against these defendants pursuant to 15 U.S.C. § 15 and 28 U.S.C. § 1391(b). Service of process is obtainable upon defendants pursuant to 15 U.S.C. § 22.

Parties

3. Plaintiff NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER ("NATIONAL GERIMEDICAL HOSPITAL") was and is a not-for-profit corporation organized and existing under the laws of the State of Missouri. On or about July 30, 1978, NATIONAL GERIMEDICAL HOSPITAL is scheduled to open and operate a 120-bed general acute care hospital licensed by the State of Missouri specializing primarily in geriatric medicine at the address set forth in the caption hereto. From and after July 30, 1978, NATIONAL GERIMEDICAL HOSPITAL will be a provider of hospital services.

4. Defendant BLUE CROSS OF KANSAS CITY ("BLUE CROSS") was and is a corporation organized and existing under the laws of the State of Missouri having and maintaining its principal place of business at the address set forth in the caption hereto. BLUE CROSS offers private individual and group health care reimbursement plans and programs to the general public in Missouri and Kansas and contracts with hospitals and other health service providers for administration of its health care reimbursement plans.

5. Defendant BLUE CROSS ASSOCIATION ("BCA") was and now is a corporation organized and existing under the laws of the State of Illinois and having its principal place of business at the address set forth in the caption hereto. BCA is a national organization offering private health care reimbursement plans and programs to national subscribers and national subscriber groups in numerous states, including Missouri and Kansas. BCA coordinates Blue Cross national policies and programs offered by local and regional Blue Cross Plans, including defendant BLUE CROSS.

Non-Party Co-Conspirators

6. MID-AMERICA HEALTH SYSTEMS, INC., ("MAHSA") was and now is a not-for-profit corporation organized and existing under the laws of the State of Missouri having its principal place of business at 20 West Ninth Street, Kansas City, Missouri 64105. MAHSA is named herein as a co-conspirator with defendants but not as a defendant at this time. MAHSA is a non-governmental organization engaged in the voluntary evaluation of health care services in its designated service area, including numerous counties in Missouri and Kansas.

7. Gary L. Ihde is Vice President, Institutional Provider Affairs, of BLUE CROSS. He is also a member of the Board of Directors and Treasurer of MAHSA. Mr. Ihde is named herein as a co-conspirator with defendants but not as a defendant at this time.

8. Elias E. Zirul, D.O., 6724 Troost, Suite 600, Kansas City, Missouri 64113, is a member of the Board of Trustees of BLUE CROSS and also is a member of the Board of Directors of MAHSA. Dr. Zirul is named herein as a co-conspirator with defendants but not as a defendant at this time.

9. Charles L. Aylward is a member of the Board of Trustees of BLUE CROSS representing the interests of the public and is named herein as a co-conspirator with defendants but not as a defendant at this time.

10. Earl E. Horton, Executive Director, Independence Sanitarium and Hospital, is a member of the Board of Trustees of BLUE CROSS representing the interests of area hospitals, and is named herein as a co-conspirator with defendants but not as a defendant at this time.

11. Independence Sanitarium and Hospital, 1509 West Truman Road, Independence, Missouri 64050, is a Blue Cross Participating Hospital under contract with BLUE CROSS and is named herein as a co-conspirator with defendants representing all Blue Cross Member Hospitals having contracts with BLUE CROSS but not as a defendant at this time.

12. Other individuals, firms or entities now unknown to plaintiff and unnamed are hereby designated as co-conspirators with defendants but not as defendants at this time.

The Nature of Trade and Commerce

13. BLUE CROSS and BCA are major providers of private health care plans in Western Missouri and Eastern Kansas; BLUE CROSS has approximately 800,000 Kansas City area individual plan subscribers. Approximately 40 percent of BLUE CROSS individual plan subscribers participate through national contracts negotiated by BCA and administered locally by BLUE CROSS. A substantial portion of all hospital admissions, in-patient and out-patient treatment

in the BLUE CROSS service area are of BCA or BLUE CROSS individual subscribers. All general acute care hospitals in the BLUE CROSS service area except NATIONAL GERIMEDICAL HOSPITAL are BLUE CROSS Participating Hospitals. BLUE CROSS individual subscribers receive one hundred percent (100%) reimbursement for all covered hospital services at a BLUE CROSS Participating Hospital. Reimbursement by BLUE CROSS is direct to such hospitals. However, BLUE CROSS individual subscribers receive only eighty percent (80%) reimbursement for the same services at a non-participating hospital, and reimbursement for services in a non-participating hospital is direct to the individual BLUE CROSS subscriber, not to the hospital.

14. BCA offers private health care plans to national organizations and groups such as National Federal Employees, United Auto Workers, United States Steel, and Western Electric Employees, throughout the United States, including Missouri and Kansas. Such national contracts are administered and performed through local BLUE CROSS plans. The negotiated terms of such national contracts control the percentage of reimbursement available to individual group members at BLUE CROSS Participating Hospitals and non-participating hospitals.

15. NATIONAL GERIMEDICAL HOSPITAL will specialize primarily in health care services for the elderly. Plaintiff is one of the first such hospitals in the United States. It is intended to serve a national constituency of the elderly through research and development of improved care for the aged. The operation of NATIONAL GERIMEDICAL HOSPITAL will involve and affect interstate commerce in its services to out of state patients, the purchase of drugs and supplies from out of state sources, the receipt of income and reimbursement from out of state insurance companies and the involvement of out of state financing to build and operate the facility.

16. On or about February 16, 1978, NATIONAL GERIMEDICAL HOSPITAL submitted its Amended Application for Blue Cross Participating Membership to BLUE CROSS, seeking a contract with BLUE CROSS as a participating hospital entitled to all the benefits thereof, including one hundred percent (100%) direct reimbursement for service to all BLUE CROSS individual subscribers.

17. On or about March 21, 1978, BLUE CROSS, acting through its Board of Trustees, denied NATIONAL GERIMEDICAL HOSPITAL participating hospital membership status for the sole and exclusive reason that NATIONAL GERIMEDICAL HOSPITAL failed to demonstrate a need for its hospital. In all other respects, the Application of NATIONAL GERIMEDICAL HOSPITAL for membership as a Blue Cross Participating Hospital met and satisfied all requirements of BLUE CROSS.

Offenses Charged

COUNT I

18. Defendants BLUE CROSS and BCA and the co-conspirators named herein, and each of them, have and are engaged in a continuous combination and conspiracy to unreasonably restrain trade in the health care market in the Kansas City, Missouri, Metropolitan Area in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1. Said conspiracy consists of a continuing combination and agreement, the nature and effect of which is to restrict plaintiff's entry into the health care market and to foreclose to plaintiff an economically significant portion of said market as follows:

(a) On January 1, 1976, BLUE CROSS and BCA established "Prerequisites for Application as a Blue Cross Participating Hospital" requiring *inter alia* evidence that an applicant hospital meets "a clearly evident need for health care services in its defined service area."

BLUE CROSS has designated MAHSA as the agency to conduct "need review" of proposed health care services for BLUE CROSS. It is established BLUE CROSS policy that failure to secure MAHSA approval will result in the denial of any Application to be a BLUE CROSS participating member hospital.

(b) No law requires any provider of health services in Missouri to seek review from nor to secure the approval of MAHSA or any other organization for any health service or hospital expenditure. No law designates or establishes any agency, group or entity in Missouri for such purpose. But for BLUE CROSS and BCA policy requiring establishment of need for proposed health services, MAHSA has no authority nor power to compel health service review nor to impose sanctions to enforce its determinations.

(c) MAHSA, at all times here pertinent, has publicly stated its established policy to prohibit and disapprove any more general acute care hospital beds in its health service area, including the Kansas City, Missouri, Metropolitan Area, and consistently has refused to consider favorably any additional hospital beds in its service area, whether in connection with new hospital facilities or as additions to existing area hospitals. No reasonable possibility of approval by or recommendation of need for NATIONAL GERIMEDICAL HOSPITAL'S 120-bed facility was or is possible through MAHSA. No such review or approval is required by any applicable law.

(d) MAHSA, through its agents and co-conspirators Gary L. Ihde and Elias E. Zirul, has stated that it will not approve plaintiff's hospital nor find any need therefor, notwithstanding plaintiff hospital's emphasis on geriatric medicine and regulations under Public Law 93-641 recognizing a special need for additional health care services and special facilities for the el-

derly. Defendants BLUE CROSS and BCA have advised NATIONAL GERIMEDICAL HOSPITAL that notwithstanding its projected cost effectiveness, BLUE CROSS will not extend Blue Cross Participating Member status to it nor enter into a Blue Cross Participating Contract with plaintiff without the prior approval of MAHSA.

(e) Defendants BLUE CROSS and BCA have combined, contracted and conspired with each other and with co-conspirator MAHSA; with each other and with co-conspirators Gary L. Ihde and Elias E. Zirul, acting in their capacities as an officer and members of the board of MAHSA; and with each other and with co-conspirators Earl E. Horton and Independence Sanitarium and Hospital, acting on behalf of and representing the interests of area hospital competitors of plaintiff, (i) to deny plaintiff hospital Blue Cross Participating Membership thereby foreclosing plaintiff's access to a significant portion of the health care services market, and (ii) to limit, restrict and foreclose plaintiff's entry into the health care services market as a health care provider on an equal basis with competitor area hospitals.

(f) Defendants BLUE CROSS and BCA have combined, contracted and conspired with each other and with all other co-conspirators named herein to interrupt, interfere with, depress or eliminate competition between and among plaintiff and other area hospitals by means of and through the aforementioned combinations and agreements to refuse to deal with and to boycott NATIONAL GERIMEDICAL HOSPITAL and to deny it the privileges and significant economic market advantages of Blue Cross Participating Hospital Membership, all under the guise of controlling and reducing health care costs but to the detriment and injury to plaintiff's business and property and to that of the general public.

COUNT II

19. Paragraphs 1 through 17 hereof are by this reference incorporated into Count II as though fully set forth at this point.

20. Defendants BLUE CROSS and BCA have and are engaged in a continuous combination and conspiracy to boycott plaintiff hospital and to refuse to deal with plaintiff hospital, thereby unlawfully denying plaintiff Blue Cross Participating Hospital Member status to the detriment and injury of plaintiff's business and property notwithstanding plaintiff's compliance with all applicable state and federal laws. Defendants' said unlawful combination and conspiracy to boycott plaintiff and defendants' concerted refusal to deal with plaintiff is a violation of Section 1 of the Sherman Act, 15 U.S.C. § 1.

COUNT III

21. Paragraphs 1 through 17 hereof are by this reference incorporated into Count III as though fully set forth at this point.

22. Defendants BLUE CROSS and BCA and co-conspirators Charles V. Aylward and others representing the public interest have combined and conspired to engage in a concerted refusal to deal with plaintiff and a continuous combination and conspiracy to boycott plaintiff hospital and to coerce all Blue Cross individual subscribers, members of the general public, to refuse to deal with and to boycott plaintiff hospital by BLUE CROSS' denial of participating hospital membership to plaintiff under the guise of health care cost containment but without justification or excuse in fact or law.

23. Approximately 800,000 BLUE CROSS individual subscribers, members of the general public, are involuntary participants in said unlawful combination and conspiracy in that said individual subscribers are economically coerced

to seek health care at competitor Blue Cross Member Hospitals and not at plaintiff hospital.

24. Each and every act, combination and conspiracy to boycott, to refuse to deal and to coerce others to boycott and to refuse to deal as alleged in Count III hereof is a violation of Section 1 of the Sherman Act, 15 U.S.C. § 1.

COUNT IV

25. Paragraphs 1 through 17 hereof are by this reference incorporated into Count IV as though fully set forth at this point.

26. The acts and conduct of defendant BLUE CROSS as alleged and set forth in Counts I, II and III hereof, constitute an unlawful abuse of its monopoly power in the private health care reimbursement plan market for the purpose of and in an unlawful effort to extend and expand its said power into the health care services market and the health care provider market in order to control market entry by health service providers and to dictate the terms of access to the health care services market and to prevent free and open competition among health care service providers, all under the guise of health care cost containment but to the detriment of plaintiff's business and property and to the detriment of the general public.

27. The acts and conduct alleged and set forth in Count IV hereof are a violation of Section 2 of the Sherman Act, 15 U.S.C. § 2.

COUNT V

28. Paragraphs 1 through 18 hereof are by this reference incorporated into Count V as though fully set forth at this point.

29. Defendants' said agreements, combinations and conspiracies constitute unlawful restraints of trade or commerce in the State of Missouri in violation of Section 416.031-1, RSMo. (1975 Supp.).

COUNT VI

30. Paragraphs 1 through 17 and paragraph 20 hereof are by this reference incorporated into Count VI as though fully set forth at this point.

31. Defendants' said agreements, combinations and conspiracies to boycott and refuse to deal with plaintiff constitute unlawful restraints of trade or commerce in the State of Missouri in violation of Section 416.031-1, RSMo. (1975 Supp.).

COUNT VII

32. Paragraphs 1 through 17 and paragraphs 22 through 24 hereof are by this reference incorporated into Count VII as though fully set forth at this point.

33. Defendants' agreements, combinations and conspiracies to coerce others to boycott and refuse to deal with plaintiff constitute unlawful restraints of trade or commerce in the State of Missouri in violation of Section 416.031-1, RSMo. (1975 Supp.).

COUNT VIII

34. Paragraphs 1 through 17 and paragraphs 26 through 27 hereof are by this reference incorporated into Count VIII as though fully set forth at this point.

35. Said acts of defendant BLUE CROSS constitute unlawful restraints of trade or commerce in the State of Missouri in violation of Section 416.031-2, RSMo. (1975 Supp.).

Injury to Plaintiff

36. By reason and as a direct and proximate result of the unlawful acts and conduct of defendants and others set forth in paragraphs 18 through 35 hereof, plaintiff NATIONAL GERIMEDICAL HOSPITAL has been and is injured in its business and property in that:

(a) Potential patients of plaintiff hospital will be unwilling to and will refuse to deal with or patronize plaintiff's hospital and to utilize the health care services offered by plaintiff;

(b) Plaintiff will be unable to attract BLUE CROSS individual subscribers who are coerced and forced to seek medical services elsewhere in order to utilize the full benefits of their BLUE CROSS subscriber contracts;

(c) By reason of substantially reduced patient access and patronage, plaintiff will be unable to attract and to maintain a high quality, full service medical staff and will be unable to maintain low cost quality health care services;

(d) Plaintiff's good will and public faith have been and will continue to be destroyed and undermined due to BLUE CROSS' combination and conspiracy to restrict entry into the health care service market and to refuse participating member hospital status to plaintiff, which unlawful actions have called into public scrutiny and doubt the propriety, efficiency and cost effectiveness of plaintiff's hospital, all without basis in fact;

(e) The value of plaintiff's hospital buildings and facility and the value of plaintiff's hospital operation has been substantially diminished and impaired;

(f) Plaintiff's ability to obtain and retain commitments for both interim and long term financing and for public financial support and for the support of foundation contributors on which plaintiff relied is substantially impaired and destroyed;

(g) Plaintiff's ability to provide low cost, effective, quality health care services to the general public and particularly the elderly has been substantially impaired and irrevocably damaged and plaintiff is and

will continue to incur disproportionate expenses and costs of operation all of which could be avoided in a free, open and competitive health care market.

Damages

37. Plaintiff does not know and has not at this time determined the full extent of its damages, but believes that plaintiff's actual damages from all causes herein alleged will exceed One Million Six Hundred Thousand and No/ Dollars ($1,600,000.00). When plaintiff has ascertained the extent of its damages, plaintiff will seek leave to amend its Complaint and allege its damages.

Prayer for Relief

WHEREFORE, plaintiff NATIONAL GERIMEDICAL HOSPITAL prays:

(a) That defendants BLUE CROSS and BCA, and each of them, be adjudged and determined to have violated the antitrust laws of the United States of America and of Missouri as herein set forth and alleged;

(b) That Plaintiff NATIONAL GERIMEDICAL HOSPITAL have judgment against BLUE CROSS and BCA, and each of them, for three times the total amount of its actual damages incurred and its reasonable attorney's fees herein incurred and expended as required by law;

(d) That defendants, and each of them, be enjoined from further violation in each and every respect hereinbefore alleged of the antitrust laws; and

(e) That plaintiff have and recover such other and further relief as the Court may deem proper.

Plaintiff hereby demands trial by jury.

JOHNSON, LUCAS, BUSH & SNAPP

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Attorneys for Plaintiff
National Gerimedical Hospital
and Gerontology Center

DEFENDANT BLUE CROSS ASSOCIATION'S MOTION TO DISMISS OR, ALTERNATIVELY, MOTION TO STAY

(Filed in the United States District Court for the Western District of Missouri, July 14, 1978)

(Title omitted in printing)

Comes now the defendant Blue Cross Association ("BCA"), pursuant to Rule 12(b), Fed.R.Civ.P., and moves to dismiss plaintiff's Complaint on the following grounds:

1. The Complaint fails to state a claim upon which relief can be granted because the McCarron-Ferguson Act exempts the challenged activity from the antitrust laws;

2. This Court lacks jurisdiction over the subject matter of the Complaint because the challenged activity does not affect interstate commerce;

3. All pendent claims arising under Missouri law should be dismissed because of the plaintiff's failure to state a claim for relief based upon federal law and because of the court's lack of jurisdiction over the federal claims; and

4. Even assuming *arguendo* that the above 3 grounds for dismissal did not exist, the Complaint must be dismissed as to BCA because the allegations made are insufficient to support plaintiff's theory of BCA's conspiracy with defendant Blue Cross of Kansas City.

Alternatively, for the reasons set forth in BCA's Suggestions, Part IA, pp. 11 and 12, fn. 4, if this action is not dismissed, it should at least be stayed pending the United States Supreme Court's decision in *Royal Drug Co.* v. *Group Life & Health Insurance Co.*, 556 F.2d 1375 (5th Cir. 1977), *cert. granted*, 98 S. Ct. 1448 (1978).

Pursuant to Local Rule 10 of this court, suggestions in support of this motion have been served on counsel of record and are filed herewith.

STINSON, MAG, THOMSON, MCEVERS & FIZZELL

By /s/ JOHN C. NOONAN by REH
John C. Noonan

By /s/ RANDALL E. HENDRICKS
Randall E. Hendricks
P. O. Box 19251
Kansas City, Missouri 64141
(816) 842-8600

Attorneys for Defendant
Blue Cross Association

(Certificate of Service omitted in printing.)

MOTION OF DEFENDANT BLUE CROSS OF KANSAS CITY TO DISMISS PLAINTIFF'S COMPLAINT

(Filed in the United States District Court for the Western District of Missouri, July 14, 1978)

(Title omitted in printing)

Defendant Blue Cross of Kansas City (hereinafter Blue Cross) moves the Court for its Order dismissing plaintiff's Complaint and all Counts thereof on the following grounds:

1. The Complaint fails to state a claim upon which relief can be granted as to this defendant.

2. The Complaint fails to state a claim upon which relief can be granted because all claims against this defendant, alleged in the Complaint, are exempted from the antitrust laws of the United States by the McCarran-Ferguson Act; this defendant is in the business of insurance and is subject to the regulation by the states of Missouri and Kansas, within the meaning of the McCarran-Ferguson Act, 15 U.S.C. 1011, *et seq.*, so that this Court lacks jurisdiction over the subject matter of this action within the meaning of F. R. Civ. P. 12(1).

3. No pendent jurisdiction exists for claims arising under Missouri law so that Counts V through VIII of plaintiff's Complaint should be dismissed as they fail to state a claim upon which relief can be granted based on Federal Law and because of the Court's lack of jurisdiction over Counts I through IV.

4. This Court lacks jurisdiction over the subject matter of this case because the claims against this defendant, based upon the sale of prepaid health insurance plans by not-for-profit corporations, is not trade nor commerce within the meaning of the Sherman Act, 15 U.S.C. 1 and 2.

5. Plaintiff's Complaint, as a matter of law, does not allege any illegal conspiracy or concerted activity within the meaning of the Sherman Act by this defendant or any other person or party.

6. Plaintiff's Complaint, and particularly Counts I through IV, fail to state a claim for relief against this defendant because plaintiff's Complaint alleges conduct of this defendant which was within the intent, directive and mandate of the National Health Care Planning Act, 42 U.S.C. 300k *et seq* and thus, not subject to the antitrust laws.

7. Defendant Blue Cross attaches and makes a part hereof, the Affidavit of Jerry B. Buxton as Exhibit A; the Affidavit of Fletcher Bell as Exhibit B and incorporates by reference the Affidavit of Donald L. Flora and the copy of the 1978-1982 Health Systems Plan of Mid-America Health Systems Agency attached to the Flora Affidavit as Exhibit A, both filed separately this date in this action because of the bulk of the Health Systems Plan.

WHEREFORE, defendant Blue Cross of Kansas prays the Order and Judgment of this Court dismissing plaintiff's Petition and for this defendant's costs herein incurred.

Respectfully submitted,

/s/ HARRY P. THOMSON, JR.
Harry P. Thomson, Jr.

/s/ GEORGE E. LEONARD
George E. Leonard

and

/s/ DENNIS D. PALMER
Dennis D. Palmer

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and

/s/ MAX O. BAGBY by Apt
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of

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Counsel for Blue Cross of Kansas City

(Certificate of Service omitted in printing.)

Attachment to the Suggestions of Blue Cross Association in Support of Motion to Dismiss.

AFFIDAVIT OF DONALD L. FLORA

(Filed in the United States District Court for the Western District of Missouri, July 14, 1978)

(Title omitted in printing)

I, Donald L. Flora, being first duly sworn on oath depose and say:

1. I am a resident of the State of Missouri and reside at 1101 Arno, Kansas City, Missouri. My business office is at 20 West 9th Street, Suite 715, Kansas City, Missouri.

2. I am the Executive Director of Mid-America Health Systems Agency and have personal knowledge of the matters referred to herein.

3. Mid-America Health Systems Agency is fully designated by the United States Department of Health, Education and Welfare as the health planning body for the eight-county, bi-state, Kansas City metropolitan area including the counties of Cass, Clay, Jackson, Platte and Ray in Missouri and the counties of Johnson, Leavenworth and Wyandotte in Kansas (hereinafter referred to as "the health systems area").

4. Exhibit A, attached hereto, is a true and correct copy of the 1978-1982 Health Systems Plan for the health systems area.

5. The 1978-1982 Health Systems Plan, identified in paragraph 4 as Exhibit A, was prepared by the Mid-America Health Systems Agency pursuant to and in accordance with Section 1513(b)(2) of the National Health Planning and Resources Development Act of 1974, 42 U.S.C. § 3001-2(b)(2).

/s/ DONALD L. FLORA
Donald L. Flora

PREVIOUS PAGE WAS BLANK

Subscribed and sworn to me by the said Donald L. Flora this 12th day of July, 1978.

/s/ INA K. PEARSON
Notary Public in and for
the State of Missouri

Ina K. Pearson, Notary Public

My Commission Expires April 10, 1981

[NOTARIAL SEAL]

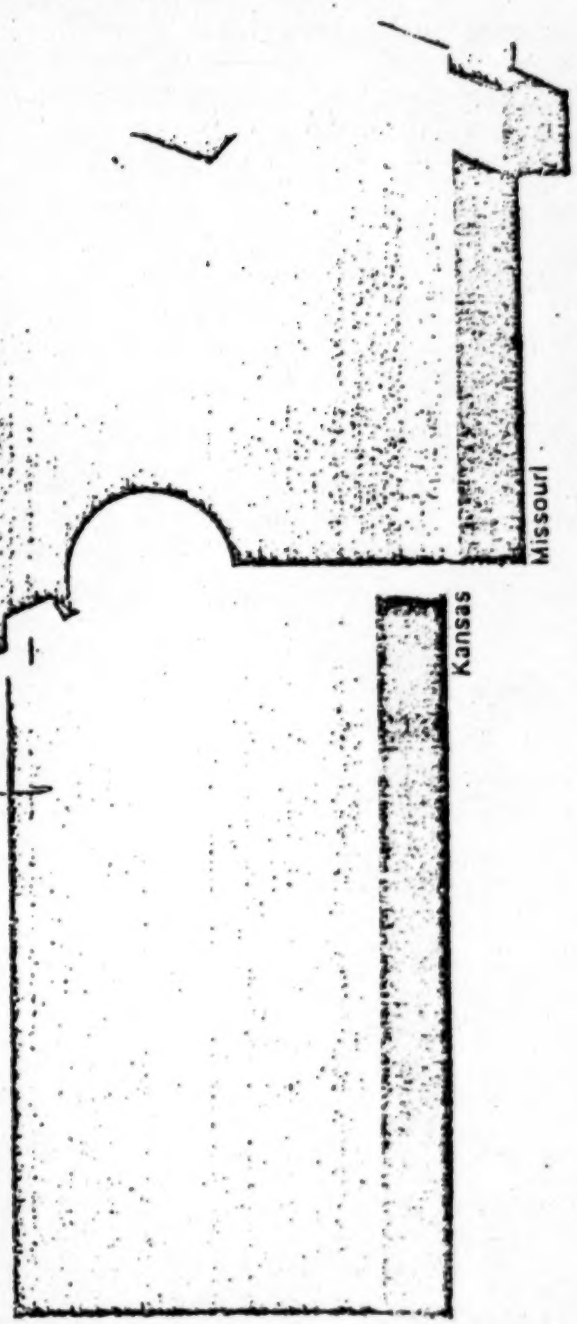
Excerpts from Exhibit A to the Affidavit of Donald L. Flora

EXCERPTS FROM HEALTH SYSTEMS PLAN 1978-1982

(Filed in the United States District Court for the Western District of Missouri, July 14, 1978)

Health Systems Plan

1978-1982



Mid-America Health Systems Agency
20 W. 9th Suite 715
Kansas City MO 64105

FOREWORD

The Mid-America Health Systems Agency was conditionally designated the health planning body for the eight-county, bi-state, Kansas City metropolitan area April 12, 1976. It is one of 205 regional health systems agencies created under Public Law 93-641, the National Health Planning and Resources Development Act of 1974.

One of the primary responsibilities of each of these health systems agencies is the development of a long-range Health Systems Plan (HSP) for the region. The HSP describes how the region's health care delivery system should be changed by the end of 1982 to make it more accessible, available and efficient.

MAHSA's 30-person volunteer Board directed July 30, 1977, that the first six chapters of the Agency's proposed HSP be submitted to the public for comments and suggested modifications.

The Board reviewed the complete HSP and suggested modifications based on these public comments November 12, 1977, and voted November 22 to establish the final HSP, as modified, as the five-year health plan for the region.

The following is the established 1978-1982 Health Systems Plan for the MAHSA region.

TABLE OF CONTENTS

MID-AMERICA HEALTH SYSTEMS AGENCY
HEALTH SYSTEMS PLAN

		Page
Chapter 1.000	INTRODUCTION	1-1
Chapter 2.000	NATIONAL PRIORITIES AND STATEWIDE NEEDS AND PRIORITIES	2-1
Chapter 3.000	GENERAL DESCRIPTION OF THE HEALTH SERVICE AREA	3-1
Chapter 4.000	HEALTH STATUS	4-1
Chapter 5.000	HEALTH SYSTEM	
	Introduction	5-1
	Consumer Health Education	5-7
	Maternal and Child Care	5-23
	Acute Inpatient Care Services	5-53
	Diagnostic Radiology	5-75
	Emergency Medical Services	5-91
	Mental Health Services	5-95
	Rehabilitation Services	5-111
	Long-Term Care	5-117
Chapter 6.000	LONG-RANGE RECOMMENDED GOALS, OBJECTIVES, ACTIONS AND INTERVENTION STRATEGIES FOR SELECTED PROBLEMS	
	Introduction	6-1
	Health Status	6-3
	Consumer Health Education	6-9

		Page
	Maternal and Child Care	6-13
	Acute Inpatient Care Services	6-19
	Diagnostic Radiology	6-25
	Mental Health Services	6-33
	Rehabilitation Services	6-37
	Long-Term Care	6-39
Chapter 7.000	Summary	7-1
Chapter 8.000	Priorities for Annual Implementation Plan	8-1
Chapter 9.000	Areas for Future Consideration	9-1
Chapter 10.000	Evaluation	10-1
Appendices	Demographic Data	Appendix A
	Health Status Data	Appendix B
	Health Systems Service Categories	Appendix C
	Health Care Cost References	Appendix D
	Maternal and Child Care Data	Appendix E
	Acute Inpatient Care Services Data	Appendix F
	Emergency Medical Services Data	Appendix G
	Mental Health Services Data	Appendix H
	Long-Term Care Data	Appendix I
	MAHSA History	Appendix J
	Glossary	Appendix K
Index		

1.000 INTRODUCTION

This introductory chapter is presented to assist the reader in understanding the purpose and use of the Mid-America Health Systems Agency's Health Systems Plan (HSP). The chapter is organized into four sections:

(1) Section *1.100, Statutory Authority,* provides an explanation of the legal basis which gives the Mid-America Health Systems Agency its authority to function.

(2) Section *1.200, The Mid-America Health Systems Agency,* summarizes the Agency's development and presents the Agency's planning policies and responsibilities.

(3) Section *1.300, Purpose and Use of the Health Systems Plan,* outlines the purpose and organization of the HSP.

(4) Section *1.400, The Process for Evaluating the Planning Effort,* expresses the Agency's intent to provide community involvement in evaluating its planning activities.

1.100 Statutory Authority

1.110 *Federal Authority*

Public Law 93-641, the *National Health Planning and Resources Development Act of 1974,* was signed into law by President Gerald R. Ford January 4, 1975. PL 93-641 amended the Public Health Service Act ". . . to assure the development of a national health policy and of effective State and area health planning and resources development programs. . ."[1]

In amending the Public Health Service Act, Congress intended to facilitate the development of recommendations

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[1] PL 93-641, 93rd Congress, S.2994, January 4, 1975, page 1.

for a national health planning policy, to authorize financial assistance for the development of resources to further that policy, and to augment areawide and state planning for health services, manpower, and facilities.

By adding two new titles to the Public Health Service Act (Title XV—*National Health Planning and Development* and Title XVI—*Health Resources Development*), Congress created a network of national, state and local health planning groups (Title XV) and a mechanism (Title XVI) to provide assistance through allotments, loans, loan guarantees and interest subsidies to medical facilities needing to modernize, construct new inpatient facilities or convert to a new form of health services.

The health planning network created under Title XV consists of four groups—one at the national level, two at the state level, and one at the local level. Each group has separate, but related and coordinated functions.

At the national level there is an advisory body known as the National Council on Health Planning and Development which advises, consults with and makes recommendations to the Secretary of Health, Education and Welfare concerning the development of national guidelines on national health planning policy, and the development and implementation of Titles XV and XVI. The Council also is charged with evaluating the implications of new medical technology for the organization, delivery and equitable distribution of health care services.

At the state level, the two groups are the Statewide Health Coordinating Council (SHCC) and the State Health Planning and Development Agency (the SHPDA or State Agency).

The major functions of the Statewide Health Coordinating Council are to prepare, review, and revise at least annually a state health plan. Based upon the state health plan, the SHCC must review annually and approve or dis-

approve any state plan and any application to be submitted to the Department of Health, Education and Welfare for funds or allotments made to the state under the Public Health Service Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970.

The State Health Planning and Development Agency (SHPDA) has many functions—the primary one being to conduct the state's health planning and development activities. The SHPDA is an agency of the state government; the SHCC is an advisory group consisting of unpaid volunteers appointed by the governor of each state.

The fourth group, which completes the network for health planning, is a local entity called a Health Systems Agency (HSA). Each health systems agency is in charge of all health planning activities in a limited geographic area called a health service area. The work of each health systems agency is guided by a governing body (unpaid volunteers) and performed by a professional planning staff.

Each HSA is responsible for:

(1) improving the health of residents of its health service area;

(2) increasing the accessibility (including overcoming geographic, architectural and transportation barriers), acceptability, continuity and quality of the health services provided;

(3) restraining increases in the cost of providing area residents health services; and

(4) preventing unnecessary duplication of health resources.

To accomplish these purposes, each HSA has as its primary responsibility the provision of effective health planning for its health service area and the promotion of

the development within the area of health services, manpower and facilities which meet identified needs, reduce documented inefficiencies and implement its health plans. The document which records the results of the planning efforts of each HSA is the Health Systems Plan.

The Health Systems Plan is a detailed statement of goals describing a healthful environment and health system for the area, which when developed, will assure that quality health services are available and accessible in a manner which assures continuity of care at a reasonable cost for all residents of the area and which is responsive to the unique needs and resources of the area.

1.120 *Kansas Authority*

The *Kansas Health Planning and Development Act*, K.S.A. 65-4701, signed by Governor Robert Bennett on April 14, 1976, authorized the establishment of a Statewide Health Coordinating Council, a State Health Planning and Development Agency in the Department of Health and Environment, and four health systems agencies within the state.

1.130 *Missouri Authority*

Missouri has not enacted specific legislation implementing PL 93-641. By administrative authority, a Statewide Health Coordinating Council and a State Health Planning and Development Agency within the Department of Social Services have been established. There are five health systems agencies in the state.

1.140 *Mid-America Health Systems Agency, Inc., By-Laws*

The Mid-America Health Systems Agency, Inc., is a private not-for-profit corporation chartered November 12, 1975, under the laws of the State of Missouri and authorized to do business in Kansas as a foreign corporation.

The Agency, with corporate offices in Missouri, is organized for the sole purpose of providing health planning for its health service area and is operated in a manner consistent with the purpose, requirements, specifications, duties and functions of a health systems agency as defined in Title XV of PL 93-641, subsequent amendments and corresponding provisions of any subsequent federal health planning legislation and related regulations and guidelines.

The Agency serves the Kansas City metropolitan area (designated Kansas Health Service Area #4—Johnson, Leavenworth and Wyandotte Counties; and Missouri Health Service Area #1—Platte, Clay, Ray, Jackson and Cass Counties).

1.200 Mid-America Health Systems Agency

1.210 *Agency History*

This section is designed to record MAHSA's history—how it was initially organized and established. The historical perspective was presented and well documented in the Agency's initial application and subsequent court case.

MAHSA's development was an open process characterized by citizen involvement and participation. MAHSA was formed by a group of dedicated citizens committed to the establishment of a freestanding, not-for-profit health planning agency that would be open to participation by the entire community and which would not be controlled by any one group. MAHSA has maintained continuous public participation in its development and has benefited greatly from this involvement. (For a detailed chronology of MAHSA's history, see Appendix J.)

1.220 *Agency Policies*

On March 24, 1977, MAHSA's Board of Directors adopted six major policies designed to provide the philosophical basis for the development of any and all health systems plans promulgated or sponsored by the Agency.

These policies define for the community what health planning responsibilities the Agency has, the commitments it tenders to the area's health care consumers and providers, and the Agency's intent to communicate and inform individuals and organizations not directly associated with it.

The six planning policies—and the reasons and implications for each—are presented below. The six policies must be viewed in their totality. Collectively they provide the parameters of the Agency's planning efforts. Individually each policy presents the Agency's statement of its responsibilities to one or more elements of the Kansas City metropolitan area.

The Mid-America Health Systems Agency:

(1) Considers Its Responsibility in Health Planning to Include the Health of the Area Residents, the Human, Environmental and Social Factors That Influence Health, and the Preventive, Curative and Restorative Health Services That Impact on the Maintenance and Improvement of the Health of the Area's Residents.

This policy defines the eventual scope of health planning. It recognizes that the health of the area residents is impacted by the total society. A policy which defines health planning in this manner allows and encourages exploring health care problems without being artificially limited. It also permits exploring solutions to these problems which may lie outside of the medical world but may have as much or more relevancy and positive impact on the problem than a medical solution. This policy does not require that the full scope of health planning ever be explored. The policy does, however, permit such exploration if priorities and resources so indicate.

(2) Will Base Health Planning on the General and Specific Needs of All Area Residents.

This policy commits the Agency to population-based planning as opposed to resource or facilities oriented planning. The policy is established so that no program can or should ever be justified on any basis other than the contribution that program or service will make to the health of the area's residents. If a resource is to be allocated to this metropolitan area, the need for that resource must be found or identified in the population, not within the sponsorship of the program.

This policy also mandates that, whenever possible, the needs of specific population sub-groups will be identified, addressed and considered.

(3) Will Develop Goals, Objectives and Activities Directed Toward an Area Health Service System Providing Quality Services That Are Available, Accessible and Acceptable to Area Residents and That Provide Continuity of Care and Contain or Reduce Costs Wherever Possible.

Policy 3 commits the Agency to developing a health delivery system that assures the most appropriate quality health services. It also mandates that a variety of criteria be utilized in developing the health service system. The policy recognizes that the provision of high quality services involves a realization that the judgment of quality contains factors which are found in an individual's value system. The system developed will represent value judgments which reflect the community value system rather than technical definitions of quality.

(4) Will Take Positions Promoting Changes in the Existing Health Care Delivery System Only When the Change Will Result in Needed Improvement in Qual-

ITY OF CARE, AVAILABILITY OF SERVICES, ACCESSIBILITY OF SERVICES, ACCEPTABILITY OF SERVICES, CONTINUITY OF CARE OR COST OF SERVICES.

Policy 4 is the Agency's commitment to the area's health care providers to make every attempt to work with the existing delivery system in order to build on the experience, strengths and organized resources in that system while striving to correct any weaknesses.

(5) CONSIDERS THAT QUALITY OF LIFE IS OF PRIMARY IMPORTANCE IN EVALUATING THE EFFECTS OF HEALTH SERVICES AND WILL TAKE QUALITY OF LIFE EFFECTS INTO CONSIDERATION IN ALL PLANS AND DECISIONS.

This policy recognizes the duality and continuous conflict of the present health care system. At the same time that the delivery system is trying to delay death, i.e., increase an individual's life span, the system attempts to do something about the individual's ability to function within that life span. An attempt to emphasize both directions suggests unlimited resources available to health care. Policy 5 recognizes that there are severe limits on resources in general and specifically those available for use by the health care system. Policy 5 presents this community's choice as to the health care system's emphasis. The policy directs that the purpose of the Kansas City area's health care delivery system be to assist area residents in achieving an individually acceptable quality of life. This policy mandates less emphasis on reactive medicine and more emphasis on preventive measures and practical public education on health matters. This policy permits emphasis on restorative measures but mandates that programs be designed to eliminate the need for restorative or recuperative services.

Policy 5 very carefully avoids defining the term "quality of life." Quality of life is a subjective matter best

left to each individual's choice. To some, quality of life means good health; to others it means a certain physical status; to still others, quality of life is defined by the individual's ability to perform certain functions.

Policy 5 requires that the Agency plan a health care delivery system which helps an individual maximize the quality of life.

(6) WILL MAKE AVAILABLE TO THE PUBLIC ALL BACKGROUND DATA, ANALYSES AND UNDERSTANDABLE STATEMENTS OF THE REASONS FOR ANY GOALS, OBJECTIVES, RECOMMENDED ACTIONS OR DECISIONS OF THE AGENCY.

The Agency recognizes a need to keep area residents informed in a meaningful way of its actions. Policy 6 presents the Agency's intention to maintain an open, public approach to planning and of communicating its actions to the community in an understandable manner.

1.230 *Agency Responsibilities*

PL 93-641 defines the Agency's legal responsibilities and purposes (Section 1.110). There is, however, another area of responsibility which is not specifically mandated by the law but is inherent in this Agency's functioning. Whatever Health Systems Plan is finally developed, two obligations must be fulfilled.

The first obligation involves the community's right to define and implement a health delivery system which accurately reflects its value system and meets its needs. The Agency has the obligation and responsibility to outline for the community alternatives and consequences of those alternatives. The Agency understands its obligation to devise a Health Systems Plan which is satisfactory to the community, while accepting the responsibility of a leadership position in helping the community make careful, thoughtful choices in the selection of a health care system.

The second obligation involves the Agency's need to be realistic in terms of what it can accomplish alone. The Agency has to assume responsibility for helping the community see and anticipate future needs and directions. The Agency realizes that without the assistance, involvement and willing participation of consumers, providers, elected officials and other community leaders, no Health Systems Plan, no matter the quality, will be implemented. The Agency has assumed a responsibility to involve the greatest number of people possible in its planning process. It is hoped that the process utilized has led to a realistic statement about the Kansas City area's health care system.

1.300 Purpose and Use of the Health Systems Plan

This section is designed to help the reader use and understand the Health Systems Plan.

1.310 *Purpose*

The purpose of the Health Systems Plan is to define a health care delivery system for the eight-county Kansas City metropolitan area which, in the year ending December 31, 1982, will improve the area residents' quality of life.

The Health Systems Plan will provide a continuing series of high level policy statements which can and should be used as a guide for resource allocation by community leaders.

Like all segments of society, the health care system has operated on the assumption that resources in general, and health care resources in particular, are unlimited. Due to the perception of unlimited resources, the health care system has tried to do a tremendous number of things without having a clear focus in mind or being cognizant of the need to consider tradeoffs in decision making.

The Health Systems Plan reflects the community's statement of the health system's goal: improvement in the qual-

ity of life. The Health Systems Plan then will suggest how important it is to the community that the health care system accomplish its goal and what resources are to be available. It then will indicate how the resources available to the health care system should be allocated in order to accomplish an improved quality of life.

MAHSA's Health Systems Plan will present a statement that defines the role and scope of the Kansas City area's health care delivery system and a recommendation as to where the system fits into the other social and economic systems which define and describe the society in which area residents function.

1.320 ***Use of the Health Systems Plan***

Using the Health Systems Plan becomes in many ways the most difficult part of the planning process. Two items need to be discussed. The first deals with the physical organization of the Plan; the other deals with implementing the Plan.

1.321

When reading the Health Systems Plan, Chapters 1.000, 2.000 and 3.000 can be considered as one unit.

Chapter 1.000 is introductory. Chapter 2.000 presents problems which someone or some organization has indicated should be examined. No attempt is made in Chapter 2.000 to judge whether or not these problems exist. The problem statements are presented only as hypotheses to be tested. They are presented as starting points with no further justification than the fact that someone has indicated a problem may exist. The Agency's investigation may not be limited to those items expressed in Chapter 2.000. Chapter 3.000 presents a display of the area's socio-economic statistics along with national and regional statistics. Statements will be made explaining the use of certain statistics

in health planning. Conclusions will be drawn in this Chapter related to the health status of the population.

Chapters 4.000, 5.000 and 6.000 are the heart and core of the Health Systems Plan. Chapters 4.000 and 5.000 are analytical in nature. These chapters analyze problems from Chapter 2.000 and data presented in Chapter 3.000. In succeeding plans, and as the state of the art develops, every problem presented in Chapter 4.000 will lead to some component in Chapter 5.000. The reverse is not necessarily true.

Chapter 6.000 presents goal statements based on the analyses done in Chapters 4.000 and 5.000. If Chapters 4.000 and 5.000 are considered analytical and final definitions of problems, Chapter 6.000 presents the results of that analysis in terms of goals, objectives and action plans.

Chapter 7.000 is an overall summary with a reconciliation between Chapters 2.000 and 6.000. Chapter 8.000 provides the basis of the Annual Implementation Plan. Chapter 9.000 outlines areas for future consideration, and Chapter 10.000 eventually will be used to evaluate the effectiveness of the Health Systems Plan.

1.322 *Utilizing the Health Systems Plan*

The Health Systems Plan is designed to present and then assist in the development of the metropolitan area's 1983 health delivery system. The formulation, definition and presentation of the proposed health care system is found in Chapters 4.000, 5.000 and 6.000.

The HSP can and should be used to INFLUENCE the development of the desired system.

The HSP, and consequently the Agency, will have *direct* influence over the allocation and expenditure of federal dollars in certain categorical areas. This influence will be exercised through the Agency's authority to review and approve or disapprove federal grant funds.

MAHSA, using the HSP as a basis, can influence the type, nature and scope of services sponsored by the area's health care institutions through the Agency's procedures for the review of new institutional services. Certificate of Need procedures, utilizing the Health Systems Plan, can also be used to influence the emphasis licensed health care institutions place on certain services.

There are two other ways in which the Health Systems Plan can be used to influence the development of the health care system. Although both ways are far more indirect than the Agency's quasi-regulatory powers, they are probably the most beneficial and productive. The Plan should be used by community leaders as a decision making tool for the allocation of local public and private health care resources. As community leaders—elected officials, corporate decision makers and leaders in the world of medicine—work on their respective priorities and budgets, the Agency's Health Systems Plan can provide guidance and expertise as to the final order of those priorities and the shape of those budgets.

The last area for influence can be found in the public arena. Users of the health care system have a right to know what demands they can make on it and the obligation to make only *appropriate* demands. The Health Systems Plan can be used to help the consumer achieve realistic expectations of the health care system and to utilize it appropriately.

1.400 The Process for Evaluating the Planning Effort

PL 93-641 requires that the end product of the planning process be evaluated by the community, the local and state A-95 clearing house, the Statewide Health Coordinating Council and the State Health Planning and Development Agency. Chapter 10.000—Evaluation of Interventions—will provide a mechanism and process for evaluating the effectiveness of the Plan and accompanying implementation

strategies. The basic approach in Chapter 10.000 will be to utilize the goals and objectives outlined in Chapter 6.000 as a baseline for measuring progress. Subsequent HSPs will reflect the results of the evaluation process outlined in Chapter 10.000.

The community and the Agency have an obligation also to evaluate the planning effort or process itself. Since this document is the Mid-America Health Systems Agency's initial Health Systems Plan, it is not logical at this point to critique and evaluate the process utilized in MAHSA's first 20 months of existence. The Agency will, during the first quarter of 1978, convene residents of the health service area who are familiar with the Agency's operations, whether or not they have actually participated in any phase of the Agency's planning efforts. The purpose of that evaluation will be to identify the strengths and weaknesses of the planning process with the commitment to maintain and build upon the positive aspects and eliminate the negative portions.

2.000 NATIONAL PRIORITIES AND STATEWIDE NEEDS AND PRIORITIES

This chapter presents the national priorities and statewide needs and priorities. These priorities are combined with health priorities of area residents, as expressed by both consumers and public officials, to form a set of health concerns. The health concerns, derived from federal, state and local concerns, will be examined in the subsequent chapters of the HSP.

Health planning priorities for MAHSA's health service area were derived by the process described in Chapter 1.000 and are presented in Chapter 8.000. The concerns listed in this chapter are the initial input into—not the results of—the planning and priority setting process.

2.100 National Guidelines and Priorities

2.110 *National Guidelines for Health Planning*

National guidelines for health planning under PL 93-641 have been issued.[1] The guidelines concerning the development of Health Systems Plans (HSPs) and Annual Implementation Plans (AIPs) were used in the design and preparation of MAHSA's Health Systems Plan.[2] Included in the guidelines are national health planning goals. These goals were not officially adopted in time to be included in the planning process for this year. The goals provided by the guidelines apply generally to the health status and health systems of the nation and may not be relevant to the needs and priorities of every health service area. National goals may not have corresponding goals at the local level in all cases, but no local goals are in conflict with the draft national goals.

2.120 *National Health Priorities*

National health priorities were established as a part of the National Health Planning and Resources Development Act. PL 93-641 requires consideration of these priorities in the formulation of national health planning goals and in the development and operation of federal, state, and area health planning and resources development programs. The following list of priorities is taken directly from PL 93-641, Section 1502:

(a) The provision of primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas.

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[1] National Health Planning and Development Act, Part A, Section 1501.

[2] Guidelines Concerning the Development of Health Systems Plans and Annual Implementation Plans, Department of Health, Education, and Welfare, November 1976.

(b) The development of multi-institutional systems for coordination or consolidation of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care and radiation therapy services).

(c) The development of medical group practices (especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations, and other organized systems for the provision of health care.

(d) The training and increased utilization of physician assistants, especially nurse clinicians.

(e) The development of multi-institutional arrangements for the sharing of support services necessary to all health service institutions.

(f) The promotion of activities to achieve needed improvements in the quality of health services, including needs identified by the review activities of Professional Standards Review Organizations under Part B of Title XI of the Social Security Act.

(g) The development by health service institutions of the capacity to provide various levels of care (including intensive care, acute general care, and extended care) on a geographically integrated basis.

(h) The promotion of activities for the prevention of disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services.

(i) The adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health service institutions.

(j) The development of effective methods of educating the general public concerning proper personal (including

preventive) health care and methods for effective use of available health services.

2.130 *Local Relevance of National Priorities*

All of the national priorities have been considered in the development of this Plan. The specific manner in which each priority problem has been considered is described in Section 2.400, Utilization of National and State Priorities.

2.200 Kansas Needs and Priorities

2.210 *Kansas Priority Health Problems*

The following problems have been presented by the Kansas Department of Health and Environment as the 1976-77 priority problems affecting the health of Kansans:[3,4]

Problem (a)	Medical Care Costs
Goals:	Reduce demand for institutional services.
	Reduce need for institutional services.
	Prevent unnecessary facilities and institutional services.
Problem (b)	Abusive Health Behaviors
Goals:	Educate and encourage people to assume responsibility for avoiding self-imposed risks.

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[3] *A Balanced Perspective on: The Health of Kansans*, Kansas Department of Health and Environment, Topeka, Kansas, December 1976.

[4] The order is the ranking given by the Kansas State Health Planning and Development Agency. This ranking was not accepted by the Kansas Statewide Health Coordinating Council, but the items were accepted.

	Increase the availability and accessibility of services which support appropriate health behavior.
Problem (c)	Care of the Aged
Goal:	Improve access of the aged population to needed primary care services, particularly in rural areas.
	Improve the availability of alternatives to institutional care for the aged population.
Problem (d)	Stressful Social Environment
Goals:	Improve availability and accessibility of support services for people experiencing stress.
	Conduct additional research on social and environmental factors which may be associated with harmful stress.
Problem (e)	Shortage of Primary Care Services (particularly in rural areas of Kansas)
Goal:	Improve the availability of primary care providers in Kansas with a special emphasis on rural areas.
Problem (f)	Emergency Medical Services
Goals:	Improve accessibility of emergency medical services to the public.
	Improve coordination among the agencies providing emergency medical serices.

2.220 *Local Relevance of Kansas Priorities*

All of the Kansas priorities have been considered in the development of this Plan. The specific manner in which each

priority problem has been considered is described in Section 2.400, Utilization of National and State Priorities.

2.300 Missouri Needs and Priorities

2.310 *Missouri Health Priorities*

The Missouri State Health Planning and Development Agency has not prepared a specific priority health problem list. Missouri does have available, however, an inventory of health related needs and priorities compiled by various state agencies.[5]

2.320 *Local Relevance of Missouri Priorities*

The Missouri inventory of health related needs and priorities has not been formed into a State Health Planning and Development Agency health priority statement, but the report has been considered in the development of various parts of the Health Systems Plan and is referenced when appropriate.

2.400 Utilization of National and State Priorities

Problem areas for special consideration are identified at the national or state level by the preceeding sections of Chapter 2.000. Local health and health service concerns have been studied by the MAHSA staff. An areawide consumer study[6] conducted in November and December 1976 produced the items listed in Table 2-1, page 2-8. These items are listed in priority order as determined by the

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[5] *An Inventory of Statewide Needs and Priorities Relating to Health*, prepared by the State Health Planning and Development Agency, Missouri Division of Special Services, Missouri Department of Social Services, 1976.

[6] *Mid-America Health Systems Agency Consumer Input Study*, a report to the MAHSA Plan Development Committee, January 1977.

consumers participating in the study. A similar study of public official concerns was carried out in March 1977, and results are summarized in Table 2-2, page 2-9.

The various areas of concern identified at the federal, state, and local levels have considerable overlap and can be combined into a single list of items. The areas of concern are listed below in Section 2.410 and guide the content of the following chapters of the HSP. They are not the HSP priorities, but are used in the development of area health priorities.

2.410 *Areas of Concern for Health Planning*

The following areas of concern have been identified as requiring special attention in the HSP. These items are not listed in rank order. Table 2-3, page 2-10, gives a cross-reference of these items to federal health priorities, state health priorities, and local consumer concerns.

(a) Medically Underserved Populations

The problem of medically underserved populations appears in a variety of types of services and in different geographic areas. Analysis is required to determine the actual problems, but general concerns are clear:

- A shortage of primary care physicians in rural areas and economically depressed areas.
- Insufficient care for convalescent and functionally limited persons, including a shortage of nursing home and home health care.
- Unavailability of emergency services locally, including transportation and treatment.

(b) Availability of Services

A number of perceived needs about local availability of services have been expressed by consumers. Anal-

ysis will be required to determine whether the problems relate to service shortage or service accessibility and distribution:

* Hospital services in close proximity to all areas.
* Public health services, including prevention and detection, in places accessible to all of the population needing them.
* Consumer health education services, especially for young persons.
* Mental health services locally available are desired by consumers, including special programs for drug abuse, alcoholism and child abuse education and counseling.
* Nursing homes near homes and families of clientele.
* General preventive services, including health education programs, should be promoted throughout the service population.

(c) Service Delivery System Improvements

Most of these items come from the federal priorities. The following specific areas are included:

* Multi-institutional coordination or consolidation of institutional health services. Included are obstetric, pediatric, emergency medical, intensive and coronary care and radiation therapy services.
* Development of medical group practices, health maintenance organizations and other organized systems for the delivery of health care.
* Multi-institutional systems for sharing support services.
* Development of geographically integrated systems for providing various levels of institutional care.

- Promotion of quality of care assurance systems.
- Increased training and use of physician assistants.

(d) Cost and Financing of Health Care

Health care costs are a major concern of local consumers and also are emphasized in PL 93-641. These concerns include:

- Increasing costs of all medical and health services.
- Special health care financing problems for many persons not qualified for group or government health financing systems.
- Problems of providing health care for indigent persons.
- Improved and uniform cost accounting and simplified reimbursement systems for health care institutions.

(e) Non-Medical Health Promotion Activities

Social and environmental factors beyond the control of the health service system are important to the health of the population, including:

- Environmental factors such as air and water quality, industrial hazards, etc.
- Personal abusive health behaviors, including smoking, overweight, etc.
- Stressful social environment.
- Nutritional practices and resources.

(f) Direction and Regulation of Health Services

- Increased consumer participation in health service planning.
- Increased public control of the development of health services.

TABLE 2-1

MAHSA CONSUMER HEALTH CONCERNS[1]

Priority Rank	*Item*
1	Cost of Health Care
2	Financing Systems for Health Care
3	Need for Local Physicians
4	Health Services for the Elderly
5	Health Education Services for the Public
6	Acceptability of Health Care
7	Local Emergency Services
8	Hospital Services Locally
9	Public Health Services—General
10	Family Planning, VD Clinics, Sex Education
11	Lack of Nursing Home Care
12	Accessibility of Health Services
13	Lack of Mental Health Services
14	Sanitation Enforcement
15	Alcohol and Drug Abuse Services
16	Lack of Communication Between Consumers and Providers
17	Child Abuse
18	Need for School Nurse Services
19	Immunization of Children
20	Nutrition/Home Services
21	General Ambulatory Services

[1] *Mid-America Health Systems Agency Consumer Input Study*, a report to the MAHSA Plan Development Committee, January 1977.

TABLE 2-2

HEALTH ITEMS FROM PUBLIC OFFICIALS[a]

Group 1—State and Regional

Problem

R-1 High cost of health services.

R-2 Lack of "teeth" in health facilities planning and regulation.

R-3 Availability of health professionals in low and moderate income areas and rural areas.

R-4 Federal and state eligibility requirements that keep the "near poor" from receiving care.

R-5 High and escalating costs of medical education and training of health professionals.

Group 2—County Officials

C-1 Need an exact definition of indigency (as related to the provision of health services).

C-2 Need to determine what services are available from all levels of government and to eliminate duplicative and ineffective services.

C-3 Need medical training center north of the Missouri River.

C-4 Medical care is too expensive for consumers and government providers.

C-5 Consolidation and coordination of health care is absent and there is no mechanism to provide such.

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[a] The top five items from each list are given here. Complete lists may be obtained from: MAHSA Plan Development Section, 20 West 9th Street, Suite 715, Kansas City, MO 64105.

HEALTH ITEMS FROM PUBLIC OFFICIALS (Continued)

Group 3—City Officials

M-1 Access to and provision for indigent health care (including home health care and ambulatory services).

M-2 Shortage (or distribution problems) of emergency medical services (including communications, 911 program, transportation, and facilities).

M-3 Availability of all medical services in rural areas.

M-4 Shortage of nursing homes (as measured by availability, acceptability, affordability and appropriateness).

M-5 Shortage of hospital beds (as measured by availability, acceptability, accessibility, affordability and appropriateness), especially in Independence. (Need more physician participation in the decision making process.)

M-6 High cost of health insurance for low to middle income persons and families.

TABLE 2-3

SOURCE OF AREAS OF CONCERN IN HEALTH PLANNING

Area	Source			Public Official [12]		
	Federal [9]	State [10]	Consumer [11]	Regional	County	City
A. Underserved Populations	a	e	3, 7, 11	3	3	1
B. Availability of Services	j	c, f	4, 5, 8, 9, 10, 12, 13, 15, 17, 18			2, 3, 4, 5
C. Service Delivery System	b, c, d, e, f, g		6, 19, 21		2,5	
D. Cost and Financing	i	a	1, 2	1, 4, 5	1, 4	6
E. Health Promotion	h	b, d	5, 14, 20			
F. Planning and Control			16	2		

[9] List of priorities from PL 93-641, page 2-2.
[10] Kansas priorities, page 2-3.
[11] Consumer health concerns, Table 2-1, page 2-8.
[12] Public officials lists, Table 2-2, page 2-9.

5.000 INTRODUCTION

MAHSA's health service system is addressed in this Chapter. The service system is presented by describing desired system characteristics and comparing them with the existing service system. Whenever there are differences between the desired system and the existing system, these differences are analyzed to determine whether or not they present problems.

Each identified problem is examined for cause and possible solutions, and corresponding goals to effect betterment are developed. Chapter 6.000 of this document elaborates the goals with objectives and potential long-term actions for each problem area.

The desired system for this health service area is based on national, regional and local standards and comparison data, as well as community values and Agency policies. The framework for describing the health service system is displayed in Appendix C, Health Service Categories for Health System Description. The major categories are:

(a) Community Health Promotion and Protection

(b) Prevention and Detection

(c) Diagnosis and Treatment

(d) Habilitation, Rehabilitation and Maintenance

(e) Personal Health Care Support Services

The initial HSP does not include all service categories. Early in the development of this HSP, the Agency recognized that analysis of the entire health delivery system was not possible given the limited resources (time and money) available to the Agency. A two-stage process was utilized to determine which elements would be addressed in the first HSP. The first stage was identification of those elements or activities which would be the subject of the Agency's regulatory or review activities. At a minimum,

those elements included most licensed health care institutions and categorical funding areas. The second stage involved examining those areas requiring regulatory or review activities and their relationship to the leading health problems as identified by the area's consumers and elected officials.

A close match existed between the regulatory activities and the problem list. Of the top five problem areas, the high cost of medical care, financing of medical care, and medical care for the elderly tie directly into regulatory activities in that the institutionalization of patients accounts for the largest single portion of all health care dollars and costs.

The development of the HSP over a period of time will represent a process of expanding content and increasing integration of the HSP with each yearly revision.

The *Community Health Promotion and Protection* section of this Chapter includes a section titled Consumer Health Education. The policies in Chapter 1.000 and problems in Chapter 2.000 of this HSP indicate that this category is especially important and that consumer health education is the only content area not currently addressed in a systematic plan by some area or regional agency.

Prevention and Detection services are not included in the system description although immunization is covered in the health status chapter and a system-related goal is developed. Prevention and detection services will be developed in subsequent updates of the HSP, and are included in Chapter 9.000, Areas for Future Consideration.

Diagnosis and Treatment have received major emphasis in this Plan. The following areas are included:

(a) Material and Child Care

(b) Acute Inpatient Care Services

(c) Diagnostic Radiology

(d) Emergency Medical Services

(e) Mental Health Services

Some of these areas will be elaborated upon considerably in HSP updates. Dental Services and Primary Care Services (other than those included in the above sections) will be added. Chapter 9.000 also provides details of future Agency planning activities in these areas.

Habilitation, Rehabilitation and Maintenance Services are presented in two sections:

(a) Long-Term Care

(b) Rehabilitation Services

These sections, particularly Rehabilitation Services, will be developed more completely in future HSPs and are listed in Chapter 9.000.

Personal Health Care Support Services are considered only as they relate through other categories in the system (e.g., acute inpatient care services). This section will be developed in the future.

The planning efforts for each service consider six criteria categories:

- availability
- accessibility
- acceptability
- quality
- continuity of care
- cost

These criteria, combined with an analysis of the need for each service, provide a basis for development of goals and priorities within each service category. One of these criteria—cost—also requires special consideration with respect to the system as a whole. The impact on health and other aspects of life from the overall cost of health care must be considered. In addition to the total cost of health care, the relative costs of various components, and amounts allocated to them, reflect the priorities of the community and country in the area of health and health care.

Health Care Costs

The growth of total health care expenditures was recognized as a concern at local, state and national levels in Chapter 2.000. Total expenditures have increased faster in the health sector than for the economy as a whole. This situation can be shown by total expenditures as a percent of gross national product (GNP):

Year	*Total Expenditure*	*% of GNP*	*Per Capita Amount*
1955	$ 17,330 (Millions)	4.5	$103.76
1960	25,856	5.2	141.63
1965	38,892	5.9	197.75
1970	69,201	7.2	333.57
1974	106,321	7.8	495.01
1976	139,312	8.6	637.97

Source: Social Security Bulletin, April 1977

In the two years after price controls were lifted from the health care industry, health care expenditures rose $33 billion, an increase of 31 percent. The economy as a whole grew much slower during this period with total GNP increasing 18 percent from 1974-1976.

Personal health care expenditures increased $29 billion. (Those items included in personal health care expenditures

are shown in Table 1, Appendix D.) The factors responsible for the increased personal health expenditures have varied since 1950.

Source of increase	1950-65	1965-71	1971-74	1974-76
	Amount of increase (in billions)			
Total	$23.1	$33.7	$24.1	$29.1
Price	10.1	16.8	10.4	22.8
Population	4.9	3.0	1.9	1.7
Changes in health care system	8.1	13.9	11.8	4.6
	Percentage distribution			
Total	100.0	100.0	100.0	100.0
Price	43.8	49.9	43.1	78.3
Population	21.0	8.9	7.9	5.7
Changes in health care system	35.2	41.2	49.0	15.9

Source: Social Security Bulletin, April 1977

Since 1974, price inflation has been the primary reason for the expanded personal health expenditures, accounting for 78.3 percent of the increase. Population growth contributed only 5.7 percent. The remaining 15.9 percent was a result of both quality and quantity changes in the health care system. Changes in medical technology and treatment have altered the composition of services used. Removal of financial barriers and an increase in the supply of services have resulted in increased utilization.

The Consumer Price Index (CPI) for the Kansas City area includes an index for medical care and a sub-category for medical services. The medical services component includes hospital service charges and professional services. Medical care includes both medical services and drugs and prescriptions. (Tables 2 and 3 in Appendix D show the medical care and medical services components of the Consumer Price Index for recent years.) The following table shows the CPI for selected years for the Kansas City area.

Consumer Price Index—Kansas City Area

Year	*Medical Care*	*Medical Services*	*All Items*
1955	58.7		78.8
1960	74.8		86.9
1965	88.2		95.5
1970	117.0	120.2*	115.8
1975	160.5	169.6	157.9
1976	174.1	184.6	166.5

* Medical Services component of the Medical Care Index was developed in 1966.

Source: U.S. Department of Labor, Bureau of Labor Statistics.

The 1976 CPI for medical care in the Kansas City area rose 8.5 percent over the 1975 value, while the medical services portion increased 8.8 percent. The overall CPI for the Kansas City area (all items) rose only 5.4 percent. Thus, health care prices are rising faster than other prices, just as total expenditures for health are increasing at a faster rate than expenditures in other segments of the economy.

Increases in price, total expenditures, and relative share of national economic resources have occurred with a changing pattern of payment for personal health care expenditures.

Source of Payment

Personal Health Care Expenditures
(Percentage distribution)

		Third Party Payments			
Year	*Direct Payments*	*Total*	*Private Health Insurance*	*Government*	*Philanthropy/ Industry*
1960	55.3	44.7	20.7	21.7	2.3
1970	40.4	59.7	24.0	34.2	1.5
1976	32.5	67.5	26.0	40.2	1.3

Source: Social Security Bulletin, February 1975, April 1977

Federal expenditures for health have been directed almost entirely to medical care intervention. The 1976 distribution of federal expenditures for health was as follows:

Health Care System	92%
Environment	5%
Human Biology	3%
Lifestyle less than	1%

Source: *The Federal Health Dollar 1969-1976,* Center for Health Policy Studies, National Planning Association, Washington, D.C., 1977

Data are not available for private expenditures for determinants of health other than for medical care. To adequately assess the impact of all determinants of health on the health status of the population, additional data relating to the price and total cost of both private and government expenditures for all aspects of health care are needed.

As expenditures in all areas of health have increased rapidly in the past several years, an ever growing share has been paid for medical care services. Of personal health care expenditures in 1960, 37.4 percent were paid for hospital care. By 1976, the total for hospital care had increased six and one half times and represented 46 percent of personal health care expenditures. During the same time period the amount spent for nursing home care increased from 1.9 percent to 8.8 percent of personal health care expenditures. (The total amount and percent of personal health care expenditures for hospital and nursing home care for selected years is shown in Table 4, Appendix D.)

The major causes of death and disability indicated in Chapter 4.000 are known to be as strongly influenced by lifestyle and environment as by medical care intervention. To the extent that health expenditures support medical interventions which result in small benefits when disease and disability are more clearly related to the influence of en-

vironmental conditions and lifestyles, resources should be directed to alternatives of nonmedical care.

The problems of total cost and allocation of resources to health will be addressed by applying the following policies in the development of priorities and action plans in the HSP:

(a) Total health care expenditures should not increase to more than 10 percent of GNP by 1983.

(b) Total resources allocated to health care in MAHSA's area should not increase more than 15 percent by 1983.

(c) The annual rate of increase in the medical care and medical care services components of the Consumer Price Index for the Kansas City area should not exceed the rate of increase for all items by more than seven percent.

(d) Total expenditures for hospital services should not increase at a rate more than the percent increase in the Medical Care Services component of the Consumer Price Index for the Kansas City area.

(e) Increased expenditures should be directed to the following areas:

1. Extension of services to all individuals through removal of financial barriers and barriers relating to accessibility and acceptability, as opposed to increased technology and intensity of services.

2. Prevention of health problems resulting from altered lifestyles and improved environmental conditions.

5.000 ACUTE INPATIENT CARE SERVICES

5.100 Problem Identification—Acute Inpatient Care Services

This section of the Health Systems Plan addresses acute inpatient care services in 35 of the area's 38 hospitals.[1] Total acute care services include medical/surgical services, obstetrics, pediatrics, and acute physchiatric and alcohol beds within non-federal community hospitals. A general overview of these services will be given with special attention paid to medical/surgical services (ages 15+ and ages 0-14), and psychiatric services. Other sections of Chapter 5.000 deal with obstetrical services.

This component is based upon MAHSA's six planning policies presented in Chapter 1.000 and the policies dealing with the redirection of health care resources presented in the Introduction to Chapter 5.000. All demand and utilization rates presented in Availability—Acute Inpatient Care Services, Sections 5.112 and 5.122, are based upon discharge, admission, patient days and occupancy rates of MAHSA area community hospitals. Current, usable patient origin information is unavailable at this time. Previous studies have shown 11.7 percent of the area's admissions are patients with residencies outside of the eight-county area.[2] All utilization projections assume that the 11.7 percent figure will remain constant.

The estimated service requirements are based upon the 1975 utilization of acute inpatient care services. Two age

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[1] The remaining three hospitals are the Rehabilitation Institute and the two Veterans Administration Hospitals (Leavenworth, Kansas and Kansas City, Missouri). Representatives from VA hospitals have participated in a "role and scope" planning effort within the VA system. MAHSA will utilize that plan after it is approved.

[2] *Hospital Discharge Study*, 1971, Mid-America Comprehensive Health Planning Agency, Kansas City Area Hospital Association, Kansas City Blue Cross Plan.

specific use rates for acute medical/surgical services have been developed: ages 0-14 and ages 15+.

5.110 *Desired Health System—Acute Inpatient Care Services*

5.111 *Cost—Acute Inpatient Care Services*

The cost of hospital care is influenced by at least the following 10 factors:

(1) increases in technology;

(2) intensity of services rendered;

(3) patient mix of the hospital;

(4) the extent of the hospital's teaching efforts;

(5) the hospital's market basket (i.e., food, energy, supplies, malpractice/liability insurance, personnel, professional fees and contracts);

(6) size of hospital units necessary for efficient operation;

(7) nature of third party reimbursement programs;

(8) cost containment efforts;

(9) total amount and rate of capital expenditures; and

(10) physician admission and utilization patterns.

The collective effect of these factors will be measured by indicators such as per diem charges, per case cost, and the amount of personal health care expenditures devoted to hospital care at national and local levels.

The 10 factors will be managed in a manner such that: 1) national hospital care expenditures will account for 46 percent or less of total personal health care expenditures; 2) hospital care expenditures in the MAHSA area will have the same or smaller percentage of total personal health

care expenditures by the end of 1982 in the Kansas City area as was experienced in 1976. This will require that:

(a) Implementation of new technology be carefully and conservatively approached;

(b) The reimbursement system promote appropriate utilization of hospital services, provide positive incentives for efficient institutions, actively encourage utilization of less costly but equal quality alternatives to inpatient care, and develop uniform reimbursement programs;

(c) Cost containment efforts designed to make the fullest use of existing facilities be implemented;

(d) Capital investment in institutions be controlled by an appropriate review agency; and

(e) Physician practice patterns regarding utilization of hospital services and admission patterns be controlled by an appropriate utilization review mechanism.

Uniform hospital statistical reports should exist so that meaningful hospital-to-hospital and year-to-year cost and utilization comparisons can be made.

5.112 *Availability—Acute Inpatient Care Services*

Determination of availability of acute care services will be calculated using the following indicators.

Indicator: Occupancy Rate [3]

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[3] Occupancy rates are adopted from guidelines established by appropriate professional societies and Hill-Burton programs.

Desired Level:	85 percent—all beds 90 percent—medical/surgical, ages 15+ 75 percent—medical/surgical, ages 0-14 85 percent—psychiatric, all ages
Indicator:	Admission Rate—Admissions/1,000 Population [4]
Desired Level:	(All Services) High—200.2 admissions/1,000 population Low—1975 admission rate of 182.4 admissions/1,000 population.
Indicator:	Average Length of Stay [5]
Desired Level:	(All Services) 7.65 days
Indicator:	Use Rate—Patient Days/1,000 Population [6]
Desired Level:	(All Services) High—1,502 days/1,000 population Low—1975 use rate of 1,396 days/1,000 population.

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[4] A range is selected in recognition of the Agency's desire to slow the historical rise in admission rates and based on the realization that achievement of an admission rate less than 1975's by 1983 is impractical.

[5] The desired level was established as 7.65 days due to uncertainty over the effects of changing medical practice, new financial restraints and increased regulatory activities.

[6] See footnote No. 4.

Medical/Surgical: Ages 0-14—1975 rate of 355 days/1,000 age-adjusted population
Ages 15+—1975 rate of 1,583 days/1,000 age-adjusted population

Psychiatry: All ages—94 days/1,000 population

The formula used to calculate the required number of beds will be either:

$$\text{Beds Required} = \frac{\text{Use Rate} \times \text{Projected Population}}{\text{365 Days} \times \text{Desired Occupancy Rate}}$$

OR

$$\text{Beds Required} = \frac{\text{Admission Rate} \times \text{Average Length of Stay} \times \text{Population Projection}}{\text{365 Days} \times \text{Desired Occupancy Rate}}$$

Application of the two formulas results in the bed need calculations for total acute care beds as shown in Appendix F, Table 10. Depending on the population projections, total acute care bed requirements in MAHSA's area by the end of 1982 will range from a low of 6,036 beds to a high of 7,651 beds. Where information is available both formulas will be used to determine bed needs since USE RATE = (ADMISSION RATE × AVERAGE LENGTH OF STAY). Since the average length of stay figure is usually difficult to obtain, the use rate formula normally will be used.

Age-specific medical/surgical and psychiatric bed need projections are shown in Appendix F, Table 5.

The area's total bed needs are presented with both high and low projections. The low projection assumes that at the end of 1982 the total population and the admissions or use rate will be the same as in 1975; the high projection uses MARC population projections for the end of 1982 and the

admission/use rate which is a continuation of the trend from 1971-1975.

The projected high admission/use rate will be realized if:

(a) large groups of the population in 1975 are not receiving services due to financial barriers and those financial barriers are removed by the end of 1982;

(b) the average age of the population increases significantly by the end of 1982;

(c) MAHSA area hospitals become major referral centers for other geographic areas;

(d) alternative levels of care are not made available (e.g., outpatient surgery, skilled nursing home services, home care programs);

(e) alternative financing programs for operations and capitalizations are not made available;

(f) the type of care traditionally rendered in an acute care setting is not altered;

(g) effective utilization review programs are not provided;

(h) solutions to the need to practice defensive medicine are not found;

(i) the personal lifestyles of area residents do not change in a manner which contributes to decreasing the unnecessary use of acute care facilities; and

(j) physician utilization of hospital services and admission patterns are the same in 1982 as existed in 1975.

A reduction by the end of 1982 in the admission/use rate trend will be realized if:

(a) large groups of the population are receiving services in 1975 and new financial barriers are imposed by the end of 1982;

(b) the average age of the population does not increase significantly by the end of 1982;

(c) MAHSA area hospitals do not become major referral centers for other geographic areas:

(d) alternative levels of care are made available;

(e) alternative financing programs for operations and capitalizations are found;

(f) the type of care rendered in an acute care setting is altered (e.g., preadmission testing, less emphasis on diagnostic admissions);

(g) effective utilization review programs are increased;

(h) solutions to the need to practice defensive medicine are found;

(i) the personal lifestyles of area residents change in a manner which contributes to decreasing the unnecessary use of acute care facilities; and

(j) physician utilization of hospital services and admission patterns change by the end of 1982.

A range in the number of total hospital bed services needed has been provided due to the uncertainty of the effects the preceding factors will have on utilization and demand for acute inpatient care.

5.113 ***Accessibility—Acute Inpatient Care Services***

The need for marshalling adequate resources to provide acceptable quality of care, and the expensive nature of acute inpatient care services, place considerable constraints

on future geographic distribution of acute inpatient services. Factors such as economics of scale, financial arrangements, and geographic and architectural barriers must be considered when accessible inpatient care is planned to ensure that no one portion of the area's population is more than 60 minutes away from acute medical care.

In determining accessibility of acute inpatient care, the following must be considered:

(a) total availability of acute care services;

(b) degree of utilization of all bed services;

(c) size of units which can maintain efficient operation;

(d) geographic distribution of the population;

(e) specialized needs of the area's sub-populations;

(f) the existence of geographic factors which act as deterrents to residents requiring a service: these factors include but are not limited to transportation networks, river and bridge locations, and general economic or market trade areas;

(g) architectural factors associated with the physical structures housing acute inpatient care services (all of the area's acute care institutions must meet the appropriate state and federal codes for licensure and safety);

(h) the nature of specialized services and the population base required to generate sufficient volume to maintain appropriate quality standards for these services; and

(i) the existence of financial arrangements which serve as deterrents to individuals requiring acute inpatient care: the elimination or minimization of such barriers recognize the individual's right to access each level of care as medically necessary.

5.114 *Quality—Acute Inpatient Care Services*

All of the community hospitals in MAHSA's health service area should meet and maintain the appropriate national, state or local standards for medical care.

The area's two Professional Standards Review Organizations (PSROs) should be utilized to measure the quality of care in the area's acute inpatient care institutions.

Each hospital should continue to increase and support ongoing efforts to monitor and upgrade its quality of care. Procedures and methodologies should be established to evaluate the outcome of the care the patient receives in addition to the process utilized to deliver that care.

5.115 *Continuity—Acute Inpatient Care Services*

Acute inpatient care institutions should become a major focal point of a health care system which assures continuity of health care at all levels. Such a system would result in a stratification of all components of the health delivery system with a high level of coordination between and among the major sponsors of care.

The organizational structure of acute care institutions should be responsive to acceptance of a changing role for hospitals if the hospital entity is to become one of the major coordinating forces in an integrated delivery system. By the end of 1982, the hospital should provide highly specialized inpatient services, with less emphasis on primary diagnostic and treatment services provided on an inpatient basis. The hospital should become a facilitator of a coordinated system which delivers care to patients at the lowest, most elementary level possible consistent with patient needs and quality of care considerations.

The development of such a system which provides for continuity of care to the patient is predicated on two key elements:

(a) each hospital in MAHSA's service area having a clearly defined role relative to the other components of the health care system; and

(b) the formation of one or more organized, formal mechanisms to effect efficient utilization, allocation, and coordination of acute care programs and resources.

5.116 *Acceptability—Acute Inpatient Care Services*

Community acceptance of acute inpatient care will depend entirely on the patient's and community's cultural backgrounds. The patient's and community's knowledge and acceptance of the need for acute care services are as important as the patient's acceptance of the care finally received.

Acceptance of acute care services should be predicated on the impact of care on the patient's illness as opposed to the hospital's economic benefit to the community.

5.120 *The Current Acute Inpatient Care System*

5.121 *Cost—Acute Inpatient Care Services*

Hospital Expenditures—The proportion of the national personal health care dollar devoted to hospital care increased from 37.4 percent in 1960 to 46 percent in 1976 (Appendix D, Table 4). Similar statistics for MAHSA's health service area are not available.

Total expenses incurred by all hospitals have increased during the past five years with the total expenses for hospitals in MAHSA's area increasing 63.5 percent from 1971 to 1975: $206,587,000 in 1971 to $337,813,000 in 1975 (Appendix F, Table 1). Expenses per adjusted inpatient day in community hospitals in the MAHSA region were almost identical to the national average in 1975 ($133 to $134).

Plant Assets—Total plant assets for most of the area's community hospitals have increased by 147 percent from 1971 to 1975 (Appendix F, Table 1). The plant assets per adjusted daily census have increased 114.3 percent locally as compared to national and metropolitan averages of 44.6 percent and 45.4 percent respectively. The MAHSA region has ranged from 1.9 percent to 50.2 percent higher than other metropolitan areas in average plant assets per adjusted daily census (Appendix F, Table 2).

Manpower—Staffing patterns of the area's community hospitals considering full-time equivalents (FTEs) per adjusted average daily census are 3.17 for the area, 2.71 for this census region, and 3.00 for the United States (Appendix F, Table 3).

Patient Expenses—Area hospitals had an average daily service charge of approximately $80 for a semi-private room, compared to the U.S. average of $90.93 in 1976.[7] Billed charges per day in area hospitals increased by more than 50 percent from 1971 through 1975.[8] The per case charges were approximately $760 in 1971 and $1,125 in 1975, a 48 percent increase. Hospital charges or expenses are not routinely available by admitting or discharge diagnosis.

Cost Containment—Information concerning cost containment efforts by area community hospitals is difficult to document. It is known that various services and programs exist which the hospitals utilize to varying degrees in an effort to contain costs while providing needed community services. These programs include preadmission testing, outpatient facilities including ambulatory surgical centers, and alternatives to inpatient care for patients with pre-acute

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[7] Survey of Semi-Private Room Charges as of January, 1977, Health Insurance Association of America.

[8] Blue Cross Plan of Kansas City, 1964 through 1976.

and post-acute conditions (rehabilitative care, including some home care programs).

Information is not available concerning the hospitals' participation in programs designed to increase the use of existing facilities (increased work week in major support services, efficient scheduling of operating suites and other diagnostic services, etc.).

5.122 *Availability—Acute Inpatient Care Services*

Total Acute Care Capacity—Total acute care capacity includes acute medical/surgical, pediatric, obstetrical and psychiatric bed services as well as intensive care and coronary care bed services. Bassinet and overflow beds are excluded and are not addressed.

Availability of acute care bed services considers an acute care bed irrespective of the geographic location of the bed or individual requiring it.

MAHSA's health service area has a total of 32 acute care general, non-federal community hospitals, two Veterans Administration Hospitals, three psychiatric hospitals and one facility devoted entirely to rehabilitation services (Appendix F, Table 6 and Map).

These hospitals had a total of 7,334 licensed beds in 1975 with 6,676 beds staffed for service. The over-all occupancy rate for licensed beds was 69.5 and 76.4 percent for staffed beds. The national, regional and metropolitan area occupancy rates were 75.0, 70.9, and 77.4 percent, respectively. During 1975, area hospital occupancy rates ranged from a low of 30.2 percent to a high of 88.2 percent (Appendix F, Table 7).

The community acute care bed-to-population ratio for MAHSA's health service area was 4.97 staffed beds per 1,000 population and 5.4 licensed beds per 1,000 population (Table 9, Appendix F). Comparable ratios for staffed beds were:

Missouri	5.3 beds/1,000 population
Kansas	5.7 beds/1,000 population
West North Central	5.8 beds/1,000 population
United States	4.5 beds/1,000 population

The admission rate (admissions per 1,000 population) for MAHSA's health service area can be found in Appendix F, Table 4. The area's admission rate has been consistently higher since 1971 than the rate for the United States as a whole. The admission rate for the North Central Region has increased at a pace faster than MAHSA's to the point that the North Central Region's rate exceeded MAHSA's rate in 1975.

The number of inpatient days per 1,000 population remained relatively constant in MAHSA's service area between 1972 and 1975, increasing by only four percent. Nationally the increase was 3.9 percent. Regionally the increase was 6.7 percent. In 1975, MAHSA's inpatient days per 1,000 population was 15.4 percent above the national rate but six percent below the regional rate (Appendix F, Table 4).

Table 4, Appendix F, indicates that the average length of stay for all beds and age groups declined by five percent from 1971 to 1975. This five percent decline is greater than that experienced nationally, in the region, and in other U.S. metropolitan areas. MAHSA's length of stay has been almost identical to the national average and generally below that shown for the region or other metropolitan areas.

Acute Medical/Surgical Bed Service Capacity—In 1975 there were 5,261 medical/surgical beds available in MAHSA's service area. Occupancy rates ranged from a low of 31.6 percent to a high of 92.5 percent. The average occupancy rate was 82.1 percent. The average length of stay ranged from 6.1 days to 9.5 days. The average length of stay was 8.2 days. Total beds, occupancy rates and length

of stay figures include intensive care and coronary care unit beds (Appendix F, Table 7). Comparable national and regional statistics are not available. Inpatient days per 1,000 population for medical/surgical beds for ages 15+ was 1,575 in 1974 and 1,583 in 1975 (Appendix F, Table 5).

A program by program analysis is not available for all services included in the medical/surgical bed capacity with two exceptions: end-stage renal dialysis and open heart surgery.[9,10] Both analyses indicate that the existing programs are sufficiently available to the population.

Pediatric Acute Care Bed Service Capacity—A total of 602 beds are formally designated as pediatric care beds and pediatric care also is available through other medical/surgical beds in the MAHSA region. Nineteen of the area's hospitals reported formal organized pediatric services. The occupancy rates ranged from 31.8 percent to 77.7 percent in a two-bed unit. The only hospital devoted exclusively to pediatric care reported an average occupancy of 69.6 percent. In 1974, admission/1,000 population ages 0-14 were 358/1,000 and 355/1,000 population in 1975. 1974 and 1975 average lengths of stay were 5.3 and 4.9, respectively (Appendix F, Tables 5 and 7).

Psychiatric Acute Care Bed Service Capacity—In 1975, there were three hospitals devoted exclusively to psychiatric care. Ten of the area's community hospitals reported organized psychiatric units. There were a total of 576 psychiatric beds, with an additional 38 beds devoted to alcohol programs. Occupancy rates ranged from a low of 50.4 percent to a high of 115.6 percent (Appendix F, Table 7). The 1975 use rate was 94 days/1,000 population (Appendix F, Table 5).

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[9] *End-Stage Renal Disease Study-Dialysis and Transplant Plan*, Mid-American Comprehensive Health Planning Agency, July 1975.

[10] *Open Heart Surgery Plan*, Mid-America Comprehensive Health Planning Agency, April 1976.

5.123 *Accessibility—Acute Inpatient Care Services*

Financial Accessibility—Nationally, about 92 percent of the expenditures for acute inpatient care were from third party payors.[11] The remaining eight percent were paid directly by the consumer. Most people over age 65 are covered by at least Medicare. Approximately 85 percent of the rest of the population are at least partially covered by some type of hospital care insurance.

A study done by a local group seeking to qualify as a federal health maintenance organization showed that the Kansas City area is about average for health insurance coverage.[12] Most, if not all, of the health insurers in the area reimburse hospital charges in one of three traditional ways: predetermined reimbursement level; negotiated billed charges; and cost. All insurance programs operate on a fee-for-service basis. There is one functioning health maintenance organization operating on a capitation basis. There exists a trend by third party payors to encourage and support alternatives to expensive inpatient care.

Kansas City, Missouri, and Jackson County, Missouri, serve as major sources of operating funds for two area institutions: Truman Medical Center and Truman Medical Center East. This support is designed to help meet city and county obligations to the medically indigent. A similar situation exists between the University of Kansas Medical Center Hospital and the State of Kansas.

Geographic and Architectural Factors—All residents of MAHSA's health service area are within, at most, one hour's travel time to the nearest acute care institution. Due to the Missouri and Kansas Rivers, two sub-areas have geographic barriers to other portions of MAHSA's service area: Clay, Platte, and Ray Counties in Missouri (the

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[11] Social Security Bulletin, April 1977.

[12] GHAA.

Northland area), and Wyandotte and Leavenworth Counties in Kansas. Three studies have shown that the existence of the two rivers does in fact create distinct economic trade areas.[13,14,15] Hospitals within these areas are new or have been recently replaced or renovated.[16] The only exception is Cushing Memorial in Leavenworth County.

Three counties (Ray, Cass, and Leavenworth) are predominately rural. The hospital in Ray County has recently undergone extensive renovation. Neither Cushing Memorial nor Cass County Memorial has undertaken any renovation. Jackson and Johnson Counties are physically contiguous and economically integrated. No geographic barriers to travel between the two counties exist. The northeast portion of Johnson County and the western one-half of Jackson County are especially oriented economically to each other. Residents of Johnson County south of Interstate 435 are less oriented to the core area. Residents east of Interstate 435 in Jackson County are oriented less to the core area than to their own sub-area.

Due to the existence of the Missouri-Kansas state line, certain state oriented preferences exist. There is also an awareness of community in many municipalities that strongly affects service utilization patterns.

Except for the Medical Center of Independence, Suburban Medical Center, and Parklane Hospital, all hospitals in Johnson and Jackson Counties have just recently completed renovation, replacement or expansion programs. Suburban, Parklane, and the Medical Center of Independence will

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[13] *Urban Research Service Report*, February 1973.

[14] *Transportation Study*, Missouri Department of Highways and Mid-America Council on Governments, 1971.

[15] *Hospital Discharge Study*, 1971, MACHPA, KCAHA, Kansas City Blue Cross Plan.

[16] Capital Expenditures Files, Mid-America Health Systems Agency.

complete their respective construction programs by 1979. Although Menorah Medical Center has expanded recently, the hospital has indicated a need for extensive renovation of its older ancillary services departments to meet safety code requirements.

Appendix F, Table 8, indicates the distribution of hospital beds by geographic or political boundaries and shows that hospital beds are not distributed according to the population.

Residents of Clay, Jackson, Johnson, and Platte Counties account for hospital discharges in roughly the same proportion as the population distribution. Wyandotte County residents account for a higher percentage of discharges than the percent of the population residing in Wyandotte County. Leavenworth, Cass, and Ray Counties account for a smaller percentage of the hospital discharges than their respective percentages of the population.[17] Imperical information is not available concerning the economic impact of the hospital's size on patient charges.

5.124 *Quality—Acute Inpatient Care Services*

Hospitals in MAHSA's service area all make use of the traditional committee structure for evaluation and monitoring quality of care within the institution.

The MAHSA area has two Professional Standards Review Organizations: the Northwest Missouri PSRO which serves the five Missouri counties and the Kansas Medical Foundation which serves the three Kansas counties. Both organizations are still in organizational and start-up phases with the Northwest Missouri PSRO being the most advanced. While the two organizations are interested in

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[17] MRI Project No. 3983-D, ***A Clinical Input-Output Study for the Kansas City Metropolitan Region,* 1975.**

quality, their initial thrust obviously is designed to help control the unnecessary expenditure of federal reimbursement funds.

With the exception of four hospitals of less than 100 beds, all hospitals in MAHSA's service area are accredited by either the Joint Commission on the Accreditation of Hospitals or the American Osteopathic Association.

All quality evaluation programs are essentially process oriented.

5.125 *Continuity—Acute Inpatient Care Services*

Community-wide programs designed to coordinate the medical care each inpatient receives are essentially nonexistent. By the nature of the area's hospital and physician practice patterns, the responsibility for coordinating a patient's care resides mainly with the patient and physician rather than with the institution. Most area hospitals have organized discharge planning programs. Most of the hospitals have at least informal referral patterns between institutions, programs, and other levels of care.

None of the hospitals in MAHSA's service area shares a common board of directors. Two have management contracts with either another local hospital or with a national hospital chain. Type of hospital ownership varies: municipalities; churches; proprietary hospital chains; and other private, not-for-profit corporations. All hospitals but one are exempt from ad valorum taxes.

The Kansas City Area Hospital Association sponsors a number of shared programs ranging from a common training program to shared purchasing arrangements and laundry services. Some hospitals participate in a community-wide consortium to coordinate residency programs.

There are no organized communications channels between or among key decision makers in the hospital community

which are specifically designated to coordinate the development of the Kansas City hospital industry.

It does not appear that each hospital in the MAHSA health service area has a clearly articulated role in the community which organizes and integrates each hospital within the various components of the health services delivery system.

5.126 *Acceptability—Acute Inpatient Care Services*

The general acceptability of the area's acute care services is usually expressed in three subjective areas.

The patient's general reaction to the type of care received in the hospital determines one type of acceptability. The patient's reaction usually depends on how long he has waited for care in areas such as the emergency room and radiology department; how "nice" the nursing staff was; and the reaction of the patient's family. For every patient with a low opinion of one hospital, there is another patient with a high opinion. Most problems occur when the patient does not have sufficient knowledge of the hospital's services.

A second subjective area relates to the political acceptability of an institution. Most communities view the hospital's physical structure with pride and see it as a viable economic force for the community. All area hospitals are acceptable to the communities in which they are located.

The third area relates to the acceptability of the acute care service to the medical profession. Osteopathic medicine is a prominent force in the medical community in addition to allopathic medicine. Three hospitals are specifically devoted to osteopathic medicine. The remaining hospitals, while predominantly oriented to allopathic medicine, do not have legal restrictions prohibiting the practice of other areas of medicine.

5.130 *Comparative Analysis—Acute Inpatient Care Services*

Comparison of the existing acute inpatient care services system as of 1975 with the desired system characteristics indicates a number of problem areas—cost, availability, continuity, measurement of quality, and acceptability. Problems with access to acute inpatient care services, regardless of level of care, are not major.

5.131 *Cost—Acute Inpatient Care Services*

Based on the indicators presented in Section 5.111, a trend analysis suggests that hospital care will account for a larger share of personal health care expenditures than is desirable.

At the present time the community does not have the ability to get an accurate estimate of costs for a given type of service from hospital to hospital. A common or uniform reporting system which allows community-wide comparisons of utilization and cost data does not exist.

Estimates of the contribution of new technology, the reimbursement system, lack of fully implemented cost containment programs, and ineffective limitations on capital investments are difficult to ascertain without comparable figures by hospital. However, Appendix F, Table 2, does indicate that the MAHSA area has a higher level of average plant assets per adjusted daily census than the nation, and either Kansas or Missouri. The major increase occurred after 1973 when a building cycle occurred in the area. Such a jump in assets would not have occurred with severe limitations on capital investments.

5.132—*Availability—Acute Inpatient Care Services*

Bed need projections and any surplus of beds are shown in Appendix F, Table 10. With a projected supply of 8,456 total acute care beds, bed need projections range from a low

of 6,036 beds to a high of 7,651 beds. A surplus of from 805 to 2,420 beds is projected to exist in the MAHSA community by 1983. It is more likely that the oversupply of beds will range from 1,772 to 2,244. These projections are based on current utilization rates and population projections for 1983. As the area population did not grow as rapidly between 1970 and 1975 as previously projected, it is unlikely that the population in 1983 will reach the projected figure. Given the projected supply of beds, the occupancy rate could range from 60.3 percent to 76.4 percent. The most likely range is from 62.0 percent to 68.1 percent occupancy (Appendix F, Table 4).

Based on the 1975 use rate, a surplus of beds is projected to exist in medical/surgical and psychiatric beds (Appendix F, Table 5). Specifically, a surplus of 1,445 beds and 83 beds is projected in medical/surgical bed services for ages 15+ and 0-14, respectively. With not all psychiatric bed utilization data available, a surplus of 167 beds tentatively is projected.

Considering the socio-economic data presented in Chapter 3.000, it is not altogether clear why MAHSA's use and admission rates are relatively high.

Possible explanations could include availability of beds, method of medical practice, lack of financial incentives to utilize other levels of care, fee-for-service orientation, or some undetected illness pattern that has not surfaced in available statistics. With the relatively high use of surgical operations, a close examination of the inpatient admissions pattern by type of service may be warranted.

5.133 *Accessibility—Acute Inpatient Care Services*

Appendix F, Table 8, shows that the total supply of beds is not distributed according to the population. A review of Appendix F, Table 7, and the map in Appendix F illustrates both the disparity of bed occupancies and population

distribution. In 1975, the highest overall utilization occurred in the larger hospitals located away from the inner city area of Kansas City, Missouri. Generally, the smaller the hospital and the farther away from the urban and surburban areas, the lower the occupancy rate. The area's two major teaching institutions had lower occupancy rates, partially due to antiquated facilities, and partially (in the case of Kansas University Medical Center Hospital) due to the internal organization of bed units.

The two areas confronting major geographic barriers (the Northland and Wyandotte County) have not experienced accessibility difficulties in terms of bed utilization.

MAHSA's Capital Expenditure Project files indicate that almost all of the area's hospitals are in physical conformance with current licensure laws. Exceptions appear to be portions of Menorah Medical Center, Kansas University Medical Center, all of Downtown Hospital, and possibly portions of Cass County Memorial and Cushing Memorial hospitals.

Surveys and plans done by the Mid-America Comprehensive Health Planning Agency indicate that accessibility to end-stage renal dialysis and open heart surgery programs is not a problem.[18]

With the developing trend toward financing alternatives to inpatient care, barriers to appropriate care at a lowered cost appear to be lessened. Problems in defining the medically indigent are common; these, in turn, may create accessibility problems. A determination of who is responsible for care of the medically indigent needs to be made.

Problems in gaining access to economical health insurance exist for individuals who have either recently retired, are unemployed or layed off.

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[18] Ibid., MACHPA End-Stage Renal Disease Study, Open Heart Surgery Plan.

Accessible alternatives to some forms of inpatient care are slowly becoming available. Hospitals are formalizing ambulatory surgical programs to the extent that the present capacity is not being fully utilized.[19,20]

5.134 *Quality—Acute Inpatient Care Services*

Information is not available on a community-wide basis which permits an objective evaluation of acute inpatient care quality. However, it is perceived that quality does not appear to be a problem in MAHSA's health service area. The manner in which quality of care is determined (i.e., process evaluation) does not appear to measure or define the expected outcome of care.

5.135 *Continuity—Acute Inpatient Care Services*

Public statements of each individual hospital's role and scope and its manner of integrating its programs and services with the rest of the community are not readily available. MAHSA is aware of several such studies done on behalf of hospitals, but has only one (North Kansas City Memorial Hospital) available at this time.

The problem of community-wide continuity of care exists. Other than MAHSA, there is not a viable mechanism which the hospital community can use to insure an appropriate allocation of resources that is responsive to community needs.

5.136 *Acceptability—Acute Inpatient Care Services*

The major problems associated with this characteristic lie in two areas. First, community leadership evaluates the

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[19] Mid-America Health Systems Agency Capital Expenditure Files.

[20] *Ambulatory Surgery Plan*, Mid-America Comprehensive Health Planning Agency, July 1974.

acceptability of an acute care institution on the basis of the institution's contribution to the area's economy rather than on the institution's overall impact on the health of area residents. The second problem can be found in the difference between the patient's expectations of the acute care delivery system and the system's ability to meet those expectations. Many patients have a tendency to place inappropriate demands on the hospital system (i.e., the patient seeking to utilize an emergency room for treatment of a common cold).

It is possible that the hospital system should assist the patient as the patient seeks to learn how to effectively utilize the health care system.

5.200 Problem Analysis—Acute Inpatient Care Services

Major Problem: The acute inpatient care system does not function in a coordinated manner which is cost effective in the delivery of acute care services at the most appropriate level consistent with quality standards.

Item #1: Hospital costs and utilization are increasing at a rate which causes expenditures for hospital care to consume an increasing share of all personal health care expenditures. As more resources are allocated to hospital care, fewer overall resources are available to support programs designed to help the individual develop a lifestyle which will decrease the need for acute inpatient care services.

Item #2: Reimbursement systems generally do not promote appropriate utilization of hospital services, provide positive incentives for efficient institutions, actively encourage utilization of less costly but equal quality alternatives to inpatient care, or utilize uniform reimbursement programs. The third party reimbursement system has a direct

impact on the utilization of health care services at all levels. Until proper fiscal incentives are provided which encourage the provision of alternative levels of care, expensive forms of care will continue to be most highly utilized.

Item #3: Active cost containment programs which encourage full utilization of a hospital's support services do not appear to be in common use. Unused capacity of expensive resources can create an unnecessary fiscal burden on the community as a whole.

Item #4: By 1983, a surplus of total acute inpatient care services ranging from 805 beds to 2,244 beds is projected for this area. Surpluses in medical/surgical services for ages 15+ (1,445 beds), ages 0-14 (83 beds), and psychiatry (167 beds) are projected by 1983.

The average per diem billed charge for the MAHSA service area in 1976 was approximately $176. A staffed, but unused hospital bed costs the hospital to maintain. The cost is estimated to be at least 60 percent of the per diem billed charges. Using only 60 percent of the 1976 per diem billed charge as the daily cost of an open but unused bed at the end of 1982, the total annual cost to the community for one surplus bed would be about $38,630 annually. The total cost to the community for the projected surplus beds could range from $31,097,150 to as high as $93,484,600 annually by 1983—the equivalent of $22 to $67 per capita in the MAHSA area.

Other consequences of the projected oversupply of acute care services and beds exist. In 1975, the use rate and admission rate for the MAHSA area were among the highest in the United States. A continuation of the trend will result in an admission rate of more than 200 per 1,000 population by the end of 1982. An examination of the area's socio-economic characteristics does not provide any rational explanation of the high use rate. Due to the projected supply of beds, the possibility exists that the beds, given ade-

quate reserves of nursing and other support personnel, will be utilized. Even with increasing pressure from utilization review programs, the capacity exists, hence, inappropriate admissions may not be discouraged.

The cost of over-utilization is measured by more than just the cost of the hospital stay. The total cost includes the possibility of increased morbidity and mortality in addition to social and emotional costs.

Item #5: There appears to be a maldistribution of acute inpatient care services. Some residents of the MAHSA area may be inconvenienced by increased travel time to reach the nearest acute care hospital. This inconvenience could also have negative consequences in terms of increased morbidity and mortality among those area residents.

Item #6: Availability and utilization of alternatives to inpatient care are limited. Many alternatives to inpatient care that are available are not being fully utilized (home care, ambulatory surgery). It is not altogether clear why many of the hospital-based ambulatory surgery programs are not being fully utilized. The potential demand has been identified. The program capacity exists. Either the physician, the patient, or the hospital administration (or some combination thereof) is not actively encouraging use of the programs.

Item #7: The expected effects of hospital care—as differentiated from other levels of care—has not been defined. A clear determination of whether or not the acute inpatient care system is consistently contributing to the health of the population is not always possible. Consequently, the benefits of the acute care system are not always clear.

Item #8: Patient care is not coordinated among all levels of institutional care. Without effective coordination in all levels of care, the possibility exists that the patient will not receive the appropriate care at the most economical cost.

Item #9: The community does not have an accurate perception of the use and value of the acute inpatient care system. So long as the public's expectations of the acute inpatient care system do not match the system's ability to meet those expectations, inappropriate demands on the system will be met with inappropriate programs and services.

Item #10: Historically, the impact of hospital cost and charges has not been felt by all consumers due to the lack of direct patient-to-provider reimbursement mechanisms. Third party reimbursement programs pay for more than 90 percent of all hospital care. The direct responsibility for payment does not rest with the recipient of care. Consequently, the patient is less concerned with hospital costs primarily due to the fact that he may never know the charges for the care received. Some experts argue that without direct fiscal responsibility, patients may demand care that is inappropriate.

Item #11: Physician practice patterns with respect to hospital services have a major impact on costs and utilization of those services. Effective cost containment in hospitals will require modification in these practices when cost and utilization can be lessened without detrimental effect on quality of care.

5.300 GOALS

5.310 *Goal #1*

Improve the health of the population in the MAHSA area through an adequately available and accessible acute inpatient care system coordinated in a manner that fosters containment of health care costs and provides quality of care in a culturally acceptable manner.

6.000 LONG-RANGE RECOMMENDED GOALS, OBJECTIVES, ACTIONS AND INTERVENTION STRATEGIES

Introduction

This chapter develops *action plans* from the five-year health status goals presented in Chapter 4.000 and the health systems goals presented in Chapter 5.000. The goals are defined more precisely by *objectives* which are to be accomplished in order to meet them.

The actions suggested have been selected as the most desirable means of accomplishing the goals and objectives listed, which generally are long-range recommendations designed to be put into effect during the next five years.

Selected *strategies* for bringing about the desired actions also are briefly listed. These strategies will be further detailed in the Annual Implementation Plans produced by the Agency each year to implement the HSP.

6.000 LONG-RANGE RECOMMENDED GOALS, OBJECTIVES AND ACTIONS—ACUTE INPATIENT CARE SERVICES

Problem—The acute inpatient care system does not function in a coordinated manner which is cost-effective in the delivery of acute care services at the most appropriate level consistent with quality standards.

6.100 Goal:

Improve the health of the population in the MAHSA area through an adequately available and accessible acute inpatient care system coordinated in a manner that fosters containment of health care costs and provides quality of care in a culturally acceptable manner.

The following objectives are considered to be of about equal priority. Availability, accessibility and cost issues are so complex and interdependent that solutions for one can-

not be done without equal consideration of the other issues. Cost issues appear to have highest priority. Because of the problem statements presented in Chapter 2.000, cost will continue to be emphasized.

Objective #1

Provide acute inpatient care services in those areas which develop geographic accessibility problems.

(1) Monitor and evaluate potential accessibility problems which may result from market trade areas or geographic barriers in the following areas:

—Areas north of the Missouri River in Missouri (Clay, Platte and Ray Counties)

—Eastern Jackson County

—Wyandotte and Leavenworth County

—Southern Johnson County

(2) Utilizing Certificate of Need legislation and procedures, MAHSA will change the geographic distribution of acute care services only as solutions are found to eliminate the overall surplus of services. Additional acute inpatient service beds will not be added to geographic areas unless the oversupply of beds is reduced and an equal number of beds are removed from service in other areas.

(3) State-oriented preferences will be recognized to the extent possible within the overall available inpatient capacity.

(4) A determination must be made as to whether or not medically indigent patients are unable to receive care due to fiscal barriers in MAHSA's area.

(5) Teaching institutions by their nature create certain accessibility problems. Consideration will be given to those problems.

Impact

Geographic accessibility will be achieved to the satisfaction of residents in the four areas listed. Many if not all of those residents' concerns over convenience will be alleviated. However, such geographic distribution will not be achieved until the overall supply problems are alleviated. A negative impact on the health of the population is not predicted. Additional capital costs to the overall community will not be incurred.

Objective #2

Provide available acute inpatient care services in accordance with projected need requirements (Tables 5 and 10, Appendix F).

Actions

(1) The service need projections set forth in Tables 5 and 10, Appendix F, will be used as a foundation for review of new institutional services and appropriateness review.

(2) The provider community, MAHSA and the general public should work together to seek alternative uses for the projected surplus capacity.

(3) An information system should be developed to accurately report admissions, discharges, length of stay and patient origin data for major service categories and disease diagnoses.

(4) The population of MAHSA's area will be studied in an attempt to determine the reasons for the apparent high utilization of acute inpatient services relative to other areas in the United States.

(5) Acute inpatient care service need projections will be reviewed and updated annually.

Impact

Additional inpatient services will not be added to the community. Consequently, additional capital costs for new or expended facilities will not be incurred so that any price increase will be limited to intensity of care, new technology or inflation. Some patients and families will travel slightly more than others but no population group is more than 30 minutes away from an acute care institution. Additional costs of travel are more than offset by savings incurred by no additional construction.

Objective #3

Establish programs which emphasize measurement of outcome of inpatient care.

Actions

(1) The patient should participate with the physician in choosing the level, type and quantity of inpatient care to be received.

(2) All hospitals should continue to use and upgrade utilization and quality evaluation programs.

(3) The Professional Standards Review Organizations should continue to develop and implement quality review programs which emphasize outcome of patients' care.

(4) Third party payors should develop and implement reimbursement programs and quality assessment programs which emphasize medical care outcomes as well as process.

Impact

The cost implications are unknown. It is anticipated, however, that if the patient works more with the physician in helping to accomplish basic objectives of the patient's

care, the savings in terms of long-term social and financial considerations, are immeasurable. Patient satisfaction will be increased and lower utilization of the overall health care system could result in a perceived higher level of health.

Objective #4

Maintain a rate of increase in total expenditures for hospital care services which does not exceed the rate of increase in the medical care services component of the Consumer Price Index.

Actions

(1) The hospital system should implement new technology in a conservative manner.

(2) Cost containment efforts designed to achieve the most efficient utilization of existing facilities and programs should be implemented.

(3) Capital expenditures by or on behalf of acute inpatient care facilities should be limited only to those expenditures necessary to replace obsolete equipment, to accommodate an increase in the intensity of care, and to reflect an institution's change in patient mix. Capital expenditures for inpatient care services should be undertaken only in those instances which will improve accessibility rather than increase the availability of inpatient beds.

(4) Third party coverage of ambulatory care services should be increased.

(5) Pre-admission testing programs should be actively implemented in MAHSA area hospitals.

(6) Third party payors and the hospital community should work together to develop uniform reporting systems and procedures such that meaningful hospital-to-hospital and year-to-year hospital cost and service-by-service utilization comparisons can be made.

(7) Certificate of Need or 1122 review programs, which levy licensure or fiscal sanctions against institutions making inappropriate capital expenditures, should be available in the MAHSA area.

(8) Efforts should be made to determine why the available capacity for ambulatory surgery is not being fully utilized, especially in view of the need for projections done by the Mid-America Comprehensive Health Planning Agency.

(9) Providers, consumers, elected officials and business and labor leaders should explore ways for helping the consumer assume a more direct role in reimbursing providers for the delivery of medical care.

Impact

Cost increases in the health care system will not be any greater than the cost increases in the rest of society. If successful, the overall savings to society in general will more than offset the social cost of increased regulation. Alternatives to inpatient care will be found and implemented. Capital expenditures will be undertaken only to accommodate technological advances and increased intensity of care. Some institutions will expend funds for renovation to meet licensure requirements.

Objective #5

Establish formal mechanisms to effect efficient utilization, coordination and allocation of acute care programs, services and resources.

Actions

(1) Each hospital entity should develop a definition of that hospital's role in the health care delivery system. The role definitions should be developed with the joint efforts of other health care providers in the same market or trade area.

(2) MAHSA and the area hospital association should coordinate efforts to effect the coordination of services.

Impact

If accomplished, all hospitals will work together in a coordinated manner to minimize unnecessary duplication of services. The impact on the area's health would be positive but unmeasurable.

Objective #6

Provide acute inpatient care services which are acceptable in terms of impact on the health of the patient.

Actions

(1) Education programs should be provided which help the consumer understand and utilize the acute inpatient care system in an efficient and cost-effective manner.

(2) Acute care institutions should provide referral arrangements which aid the institution in developing an appropriate response to the patient's needs.

(3) Leaders of area business, labor and political communities should be provided opportunities to understand the purpose and value of acute care institutions.

(4) Revisions to MAHSA's plan for acute inpatient care services will utilize community-wide input.

Impact

A greater degree of patient satisfaction will result.

7.000 HEALTH SYSTEMS PLAN—SUMMARY

7.100 The Health Systems Plan

The Mid-America Health Systems Agency has produced the area's first Health Systems Plan (HSP) under the

National Health Planning and Resources Development Act of 1974 (Public Law 93-641). The Plan describes the population of the eight-county Kansas City metropolitan area,[1] indicators of the area's health status, and its health care system.

The Plan then describes the *desired* health care delivery system and compares it with the *existing* system to identify needs and problems. The product of this process is a set of five-year goals, objectives and action steps to improve the health of area residents and the health care system that serves them.

The HSP is designed to be a comprehensive and integrated plan for the health and health care of area residents. The development of a complete HSP will require more than one year because of the wide range of content necessary. Selection of topic areas for the first year was based on the following factors:

(1) services that will be reviewed under state Certificate of Need laws;

(2) areas identified as special concerns in Chapter 2.000 of the HSP;

(3) availability of data and other planning resources.

Most of the identified concerns were addressed either in detail or an introduction was developed for future expansion. The development of a primary care service section, and the expansion and updating of the mental health, emergency care and rehabilitation sections of the Plan are essential for the production of a comprehensive HSP. MAHSA will give these areas high priority in its second-year planning efforts.

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[1] Counties in MAHSA's service area are Johnson, Leavenworth, and Wyandotte in Kansas, and Cass, Clay, Jackson, Platte, and Ray in Missouri.

Each section of the Plan describes the desired health status or health service system characteristics for the area, compares that description with the existing and projected health status or health services, and establishes goals wherever problems are identified. The projections and goals have a five-year perspective—January 1978 through December 1982.

7.200 The Health Planning Process

Development of the Health Systems Plan followed federal guidelines and MAHSA planning policies to produce a document responsive to the needs and priorities expressed by the community and federal and state health planning authorities.

The planning process involved community task forces, including MAHSA Board members, community technical advisory groups, and MAHSA staff. The draft plans were reviewed by the community, both consumers and providers, and their comments were taken into account before final adoption of the HSP.

There will be a yearly update of the HSP and increasing community participation should result as consumers and providers become more aware of the Plan, the planning process, and as the Plan's content is expanded.

7.300 Health Systems Plan Content

7.310 *Health Status*

MAHSA's initial study of the health status of the area's residents indicates that the major problems apparent are chronic diseases and social problems. These problems are evident in the area's death rates and the Plan calls for educational programs, and primary and secondary prevention measures to reduce premature deaths due to vascular diseases, diseases of early infancy, accidents, influenza and pneumonia, and homicides. These problems are known to be

impacted more by changes in personal lifestyles than by traditional treatments.

The infant mortality rate of 15.2 deaths per 1,000 live births in the MAHSA area is considered higher than necessary and a goal has been established of 12.0 deaths per 1,000 live births by 1983 for any of the region's sub-areas or population groups. Education of parents and potential parents in pre- and post-natal health practices, and better service coverage are seen as the most immediately effective methods of reaching this goal. Particular target areas are identifiable, the most evident being the nonwhite population where the infant mortality rate is double the rate for the white population (25.7 deaths per 1,000 live births for nonwhite residents compared to 12.7 deaths per 1,000 live births for white residents).

7.320 *The Health Care System*

The major emphasis in the health systems section of this first Plan is on availability, accessibility and cost of services. The other health systems characteristics—quality, acceptability and continuity of care—also have been addressed as appropriate.

Health Education—The kinds of health problems identified in the health status analysis, and community interest expressed in expanded health education services, are addressed in the consumer health education component of Chapters 5.000 and 6.000. This component emphasizes the need for consumer education aimed at changing personal lifestyles and health service use behaviors that impede health maintenance. The Plan emphasizes the need to develop basic health promotion and maintenance programs, and to coordinate existing disease or health problem-specific education activities for persons of all ages in a variety of service settings. Early education, involving all parts of the public school system, is posited as an essential part of the desired system.

Maternal and Child Care—Two general problems are found in the area of maternal and child care. The first is insufficient use of prenatal care services by more than one-fourth of the region's obstetrical patients. This problem requires both the development of outreach prenatal clinics and the development of school and public education programs for prospective mothers and families.

The second problem is underutilization of area hospital obstetrical facilities, which has a detrimental effect on quality and increases costs. The Plan recommends a reduction in the number of hospital obstetrical services from the existing 25 units to no more than 16 units by 1983.

Acute Inpatient Care—The acute inpatient care system in the service area is found to be meeting the service needs of area residents. The major problems found in this area center around coordination of services. Problems exist with respect to using the most economical level of service consistent with medical necessity, and with excess capacity of acute care services. There will be an estimated surplus of 800 to 2,400 acute care beds by 1983. The extent of the surplus, as explained in the Plan, will be dependent upon the rate of growth of the population and the utilization rate of hospital services.

The problems in acute inpatient care services are significant contributors to the problems of increasingly high hospital and overall health care costs.

The HSP's goals, objectives and recommended actions for acute inpatient care call for more cost effective delivery and use of hospital services through limiting inpatient capacity; encouraging use of alternative services; increasing integration of all health services; and educating consumers in the appropriate selection and use of acute care services.

Diagnostic Radiology—Computed Tomography (CT) scanners are the only topic addressed in this component.

The cost of CT equipment and the personnel necessary to use them effectively are significant enough that the number of CT scanners in the area must be held to the absolute minimum necessary to make CT services available and accessible to area residents. The Plan calls for limiting the number of full-body CT scanners in the area to 10 and placing such equipment only in hospitals that can be expected to fully utilize it and that provide a full range of treatment services (generally hospitals with 300 or more beds).

Emergency Medical Services—The activities of the Mid-America Regional Council Emergency Rescue (MARCER) system directed toward coordination of existing communication and transportation services for emergency medical care provide a basis for identification of service gaps and accessibility problems in subsequent Plan updates.

Mental Health Services—Determination of service needs and lack of coordination within the mental health services and between mental and other health services are found to be the major problems in the area's mental health care delivery system. Recommendations call for mechanisms to promote better coordination and for increased efforts to define service needs more specifically.

Rehabilitation Services—A preliminary examination of area rehabilitation services was done for this first Health Systems Plan and will be expanded as the Plan is revised yearly. Although evidence is not yet conclusive, there is reason to believe that continuity of care problems and financial barriers may be preventing many persons from receiving needed services. As such unmet needs are documented, the adequacy of available service capacity will be reassessed.

Long-Term Care—There is a projected shortage of approximately 1,750 long-term care beds in the MAHSA area by 1983. In addition to the need for beds there is also a

shortage of services in some existing homes. A number of homes in 1974 did not meet desired quality standards. There are problems with continuity of care, particularly in placing patients in homes providing the appropriate level of care. These continuity problems may have been due to financial accessibility barriers.

The five-year actions outlined in the HSP call for increased availability of services, improved quality of care, and a financing system that increases access to appropriate levels of care for area residents in need.

7.400 Health Systems Plan Conclusions

The overall indications of MAHSA's study of the health status of area residents and the health care system that serves them are: (1) that the most effective method of improving health is by reducing behavioral risk factors (smoking, overweight, early teen pregnancies, etc.); (2) that the outcomes of effectiveness and cost effectiveness of medical care services could be most improved by better coordination of health services to provide more appropriate utilization of services; and (3) that cost control measures are necessary in medical services and that more funds should be allocated to non-medical health services.

8.000 PRIORITIES FOR ANNUAL IMPLEMENTATION PLANS

The Health Systems Plan covers a five-year time frame and implementation will be programmed over that period in a series of five Annual Implemention Plans. Priorities are assigned on the basis of the scope and importance of the goal, the stage of development of the service, and the stage of development of the Plan. The priorities indicate the emphasis to be placed on the service or goal over the five-year period, but not necessarily the order in which developmental activities will occur.

8.100 First Priority Items

8.110 *Consumer Health Education*

The potential impact on health and cost of health care to be realized from improved healthful lifestyles and more appropriate use of health care services is considered to be extensive but presently untested. The process of maximizing the effectiveness of existing resources for consumer health education should begin as soon as possible. As this coordination and redirection of efforts progresses the need and potential gain from increased resources directed to this area can be determined. Implementation of the Plan's consumer health education component thus has a high priority and implementation will begin with the 1978 Annual Implementation Plan.

8.120 *Acute Inpatient Care Services*

Acute inpatient care services are the largest single component of the health care system. Measures to produce better coordination, more effective utilization, and to avoid excess capacity are a number one priority for implementation. The HSP actions for acute inpatient care services will be initiated beginning with the 1978 Annual Implementation Plan.

8.130 *Mental Health Services*

Chapter 2.000 indicated that federal, state and local concern over mental health problems and services make this area an important problem. This HSP does not contain a fully developed mental health services component. Nonetheless, it is clear that coordination of mental health services and determination of mental health care needs, more effective service mechanisms, and more effective financing mechanisms are a number one priority item for the HSP. Elaboration and completion of this HSP component and the beginning implementation of the actions suggested in it will be included in the 1978 Annual Implementation Plan.

8.140 ***Primary Care Services***

A primary care component for the Health Systems Plan will be included in the 1979-1983 HSP and primary care implementation measures will be a part of the 1979 Annual Implementation Plan. These services are given a number one priority because of the federal and state priorities with which MAHSA worked and because primary care services were emphasized by local consumers.

8.150 ***Long-Term Care***

Long-term care services are placed in the first priority category because of consumer concern and the anticipated increase in need for services and cost of services. HSP actions will be included in the 1978 Annual Implementation Plan.

8.160 ***Ambulatory Surgery***

Ambulatory surgery services were not covered in the current Plan. A section on these services, determining need levels, will be included in the 1979-1983 HSP.

8.200 Second Priority Items

8.210 ***Maternal and Child Care***

The HSP actions for maternal and child care problems and services will be initiated in the 1978 Annual Implementation Plan. The overall area is considered a second-level priority, but it must be noted that aspects of this service area are covered under consumer health education, primary care services, and acute inpatient care services.

8.220 ***Emergency Medical Services***

The emergency medical services component will be developed in the 1979-1983 HSP. Upon completion of that component, AIP objectives and actions will be developed.

8.230 ***Rehabilitation Services***

Assessment of rehabilitation services and needs will be continued with the 1979-1983 HSP. Any required actions will be included in the 1979 Annual Implementation Plan.

8.240 ***Prevention and Detection Services***

A health status goal in this HSP necessitates AIP objectives and corresponding actions for immunizations. The overall area of prevention and detection as classified in Appendix C is given a second-level priority. This should not be confused with community health promotion and protection which has been given a higher priority under consumer health education, primary care and mental health. Various screening approaches to secondary prevention will be examined and placed in the priority system in subsequent Health Systems Plans.

8.300 Third Priority Items

8.310 ***Environmental Quality Management***

Problems in the area of environmental quality management are given a third-level priority for the 1978 Annual Implementation Plan. These problems are the direct responsibility of a number of planning and governmental agencies and therefore are not assigned a high priority for the 1978 Annual Implementation Plan. Environmental effects on health are an important part of the content of the consumer health education component of this HSP and will be addressed under those activities. The health status section of the HSP will be further elaborated. Health problems that are closely related to environmental factors will be addressed in future Annual Implementation Plans.

8.320 ***Diagnostic Radiology***

The actions recommended in this HSP for diagnostic radiology will be included in the 1978 Annual Implementation Plan.

APPENDIX D

HEALTH CARE COSTS

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APPENDIX D

Table 1

National health expenditure, by type of expenditure and source of funds, fiscal years 1974–76

[In millions]

Type of expenditure	Total	Source of funds					
		Private			Public		
		Total	Consumers	Other [1]	Total	Federal	State and local
	1976 [2]						
Total	$139,312	$80,492	$75,622	$4,870	$58,820	$39,863	$18,957
Health services and supplies	131,022	77,722	75,622	2,100	53,300	36,247	17,053
Personal health care	120,431	72,013	70,457	1,556	48,417	33,683	14,735
Hospital care	55,400	25,004	24,352	652	30,396	21,394	9,002
Physicians' services	26,320	19,718	19,700	18	6,632	4,884	1,748
Dentists' services	8,800	8,131	8,131		669	288	181
Other professional services	2,400	1,607	1,559	48	793	540	254
Drugs and drug sundries	11,168	10,144	10,144		1,023	550	474
Eyeglasses and appliances	1,920	1,806	1,866		114	61	53
Nursing-home care	10,600	4,744	4,706	38	5,856	3,417	2,439
Other health services	3,933	800		800	3,133	2,548	585
Expenses for prepayment and administration	7,336	5,709	5,165	544	1,627	1,322	306
Government public health activities	3,255				3,256	1,243	2,012
Research and medical-facilities construction	8,290	2,770		2,770	5,520	3,616	1,904
Research [3]	3,327	258		258	3,069	2,818	251
Construction	4,963	2,512		2,512	2,451	798	1,653
Publicly owned facilities	1,673				1,673	37	1,636
Privately owned facilities	3,290	2,512		2,512	778	761	17

	1975 [4]						
Total	$122,231	$71,361	$66,584	$4,776	$50,870	$34,126	$16,744
Health services and supplies	114,652	68,450	66,584	1,875	46,192	31,047	15,145
Personal health care	105,745	63,779	62,447	1,331	41,966	28,866	13,100
Hospital care	48,224	21,690	21,146	544	26,534	18,371	8,163
Physicians' services	22,925	17,217	17,202	15	5,708	4,170	1,538
Dentists' services	7,810	7,409	7,409	----	401	249	152
Other professional services	2,190	1,581	1,541	40	609	416	193
Drugs and drug sundries	10,269	9,416	9,416	----	853	454	399
Eyeglasses and appliances	1,785	1,679	1,679	----	106	59	47
Nursing-home care	9,100	4,086	4,054	32	5,014	2,917	2,097
Other health services	3,442	700	----	700	2,742	2,231	511
Expenses for prepayment and administration	5,954	4,681	4,137	544	1,273	1,040	233
Government public health activities	2,953	----	----	----	2,953	1,141	1,812
Research and medical-facilities construction	7,579	2,901	----	2,901	4,678	3,079	1,599
Research [3]	2,942	250	----	250	2,692	2,453	239
Construction	4,637	2,651	----	2,651	1,986	626	1,360
Publicly owned facilities	1,413	----	----	----	1,413	69	1,344
Privately owned facilities	3,224	2,651	----	2,651	572	556	16
	1974 [4]						
Total	$106,321	$64,809	$59,836	$4,973	$41,512	$27,499	$14,013
Health services and supplies	99,330	61,581	59,836	1,748	37,746	24,928	12,818
Personal health care	91,315	57,259	56,039	1,220	34,056	22,974	11,082
Hospital care	41,050	19,594	19,081	513	21,456	14,334	6,893
Physicians' services	19,742	15,083	15,069	14	4,659	3,363	1,296
Dentists' services	6,870	6,544	6,544	----	326	211	115
Other professional services	1,929	1,497	1,459	38	432	284	148
Drugs and drug sundries	9,416	8,684	8,684	----	732	400	331
Eyeglasses and appliances	1,674	1,583	1,583	----	91	50	41
Nursing-home care	7,470	3,649	3,619	30	3,801	2,277	1,524
Other health services	3,214	625	----	625	2,589	1,855	734
Expenses for prepayment and administration	5,483	4,325	3,797	528	1,158	995	164
Government public health activities	2,531	----	----	----	2,531	959	1,572
Research and medical-facilities construction	6,991	3,225	----	3,225	3,766	2,571	1,195
Research [3]	2,527	227	----	227	2,300	2,078	222
Construction	4,464	2,998	----	2,998	1,466	493	973
Publicly owned facilities	1,204	----	----	----	1,204	246	958
Privately owned facilities	3,260	2,998	----	2,998	262	247	15

[1] Includes spending by philanthropic organizations and for providing industrial in-plant health services.
[3] Preliminary estimates.
[3] Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies excluded from "research expenditures" but included in the expenditure class in which the product falls.
[4] Revised estimates.

Source: Social Security Bulletin, April, 1977

APPENDIX D

Table 2

U. S. DEPARTMENT OF LABOR
BUREAU OF LABOR STATISTICS
WASHINGTON, D.C. 20212

CONSUMER PRICE INDEX FOR URBAN WAGE EARNERS AND CLERICAL WORKERS

KANSAS CITY, MO.-KANSAS

MEDICAL CARE--SERIES F

(1967 = 100)

YEAR	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	AVG.
1946													
1947	39.6	40.1	40.3	40.4	40.4	40.5	40.4			41.0			40.6
1948	42.4			43.7			43.8			44.5			43.7
1949	44.5			44.6			44.9			45.1			44.8
1950	45.0			45.3			45.3			46.7			45.8
1951	47.0			47.4			47.7			48.3			47.8
1952	48.9			49.2			51.0			51.0			50.3
1953	51.3			51.4			51.4			51.5			51.4
1954	51.7			58.3			58.6			58.6			57.4
1955	58.6			58.6			58.8			58.8			58.7
1956	58.8			59.5			59.5			64.5			61.1
1957	64.5			64.7			64.8			65.6			65.0
1958	65.8			65.9			73.1			73.1			70.0
1959	73.1			73.4			73.6			73.7			73.6
1960	74.0			74.5			75.4			75.1			74.8

1961	75.2		78.0		77.8		78.4		77.7		
1962	78.7		78.9		79.3		79.4		79.1		
1963	79.6		79.7		79.9		80.3		79.9		
1964	80.4		80.9		86.7		86.6		84.1		
1965	86.7		87.3		87.8		89.2		89.8	88.2	
1966		92.6		93.4		93.9		94.6	93.3		
1967		99.2		99.8		101.7		101.7	100.0		
1968		105.6		106.7		107.2		109.0	106.5		
1969		110.6		112.4		113.3		113.6	112.1		
1970		115.0		116.6		118.3		120.4	117.0		
1971		122.1		123.9		126.9		126.8	124.4		
1972		127.8		128.9		129.6		131.8	129.1		
1973		134.1		134.5		135.2		138.8	135.1		
1974		144.0		147.0		151.5		153.2	147.7		
1975		159.3		159.4		162.1		165.3	160.5		
1976		170.3		174.2		175.2		182.2	174.1		
1977											
1978											
1979											
1980											

APPENDIX D

Table 3

U.S. DEPARTMENT OF LABOR
BUREAU OF LABOR STATISTICS
WASHINGTON, D.C. 20212

CONSUMER PRICE INDEX FOR URBAN WAGE EARNERS AND CLERICAL WORKERS

KANSAS CITY, MO.-KANSAS

MEDICAL CARE SERVICES--SERIES M-4

(1967 = 100)

YEAR	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	AVG.
1966												93.1	.0
1967			98.9			99.7			102.1			102.3	100.0
1968			107.2			108.3			109.0			111.0	108.2
1969			113.0			114.9			115.9			115.9	114.5
1970			117.7			119.6			121.8			124.3	120.2
1971			126.1			128.5			131.9			131.5	128.9
1972			132.7			134.2			135.0			137.2	134.3
1973			139.9			140.5			141.2			145.5	141.1
1974			151.8			155.6			160.1			161.4	155.9
1975			168.3			168.1			171.4			175.0	169.6
1976			180.9			184.3			185.7			193.9	184.6
1977													
1978													
1979													
1980													

APPENDIX D

Table 4

HOSPITAL CARE

Year	Total Amount (Millions)	% of Personal Health Care Expenditures
1960	$ 8,499	37.4%
1965	13,152	39.3
1970	25,879	43.1
1974	41,020	44.9
1976	55,400	46.0

NURSING HOME CARE

Year	Total Amount (Millions)	% of Personal Health Care Expenditures
1960	$ 480	1.9%
1965	1,271	3.8
1970	3,818	6.4
1974	7,450	8.2
1976	10,600	8.8

Source:

Social Security Bulletin, February, 1975 and April, 1977

APPENDIX F

ACUTE INPATIENT CARE SERVICES DATA

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APPENDIX F
Table 1
EXPENSES AND ASSETS
MAHSA COMMUNITY HOSPITALS

Year	Expenses (in thousands) Total	%Inc.	Plant Assets (in thousands) Total	%Inc.
1971	$206,587	--	$147,665	--
1972	227,915	10.3	174,466	18.1
1973	259,802	13.5	177,070	1.4
1974	290,265	12.2	262,776	48.4
1975	337,813	16.4	365,286	39.0

*Does not include Leavenworth and Ray Counties
Source: Hospital Statistics, American Hospital Association, Various Years.

Table 2
AVERAGE PLANT ASSETS PER ADJUSTED DAILY CENSUS
MAHSA COMMUNITY HOSPITALS

Year	SMSA (Kansas Portion)	SMSA (Missouri Portion)	Total SMSA*	United States Metro Areas	United States Total
1971	$33,605	$27,802	$29,362	$28,802	$27,292
1972	38,105	31,960	33,560	32,133	30,467
1973	36,135	32,454	33,478	34,828	32,875
1974	81,718	34,321	46,773	37,428	35,443
1975	97,745	50,704	62,927	41,895	39,476

*Does not include Leavenworth and Ray Counties.
Source: Hospital Statistics, American Hospital Association, Various Years.

Table 3
STAFFING PATTERNS
MAHSA COMMUNITY HOSPITALS

	Total SMSA*	United States Metro Areas	United States Total
FTE Personnel/Bed	2.81	2.73	2.54
FTE Personnel/Adjusted Average Daily Census	3.17	3.12	3.00
Average FTE Annual Wage	$7,970	$9,048	$8,635

*Does not include Leavenworth and Ray Counties.
Source: Hospital Statistics, American Hospital Association, Various Years.

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APPENDIX F
Table 4

ADMISSIONS, OCCUPANCY RATES, AVERAGE LENGTH OF STAY IN COMMUNITY HOSPITALS

	1971	1972	1973	1974	1975	Projected Number of Admissions Based on 1975 Admissions/1,000 1982[1]	1982[2]	1982[3]	Projected Number of Admissions Increase Based on 71-75 Trend 1982[1]	1982[2]	1982[3]
Number of Beds-HARSA											
Staffed	6,189	6,234	6,514	6,611	6,676						
Licensed					7,334						
Approved*						8,456	8,456	8,456	8,456	8,456	8,456
Total Admissions-HARSA	222,147	231,736	235,516	241,355	244,851	244,851	251,812	282,720	268,688	276,386	310,310
Admissions/1,000 Population											
HARSA	169.1	172.0	173.7	178.8	182.4	182.4	182.4	182.4	200.2	200.2	200.2
U.S.	146.2	147.5	150.9	155.5	158.0						
N. Central Region	NA	166.2	172.2	177.9	183.0						
Occupancy Rates											
HARSA (Staffed Beds)	78.7	78.4	76.3	77.0	76.4	60.3	62.0	69.6	66.2	68.1	76.4
HARSA (Licensed Beds)					69.5						
U.S.	76.7	75.4	75.7	75.6	75.0						
N. Central Region	72.4	70.8	71.4	71.5	70.9						
U.S. Metro Areas	79.3	77.9	78.0	78.0	77.4						

Average Length of Stay					
MAHSA	8.0	7.7	7.7	7.7	7.65
U.S.	8.0	7.9	7.8	7.8	7.7
N. Central Region	8.5	8.3	8.3	8.3	8.1
U.S. Metro Areas	8.3	8.1	8.0	8.0	7.9
Inpatient Days/1,000 Population					
MAHSA		1,337	1,354	1,376	1,396	1,502
U.S.		1,163	1,180	1,207	1,209	
N. Central Region		1,387	1,424	1,468	1,481	

• Currently Approved by Planning Agencies

1 Assumes no population growth 1975-1982 (1,342,100)
2 Assumes increase in population based on 1970-1975 trend (1,380,550)
3 Assumes MARC population projections (1,550,000)

Note: Admissions projected through year-end 1982.

Sources: Missouri Center for Health Statistics
Kansas Hospital Association
Missouri Hospital Director
Licensed Medical Facilities in Kansas
AHA Guide to the Health Care Field, 1971-1975
Hospital Statistics, AHA, 1971-1975

APPENDIX F

Table 5

CURRENT UTILIZATION RATES AND PROJECTED BED NEEDS MEDICAL/SURGICAL--PEDIATRICS--PSYCHIATRIC BEDS MAHSA HOSPITALS

Year	Medical/Surgical			Pediatrics			Psychiatric	
	Beds	Admissions	Inpatient Days	Beds	Admissions	Inpatient Days	Beds	Inpatient Days
1974	5,237	194,594	1,557,547	562	24,371	129,379		
Occupancy rate	81.5%			63.1%				
Average length of stay		8.0			5.3			
Inpatient days/1,000 population			1,575			358	576	126,522*
				602	25,261	123,218	75.7%*	
1975	5,261	191,525	1,575,702	56.1%				94*
Occupancy rate	82.1%				4.9			
Average length of stay		8.2				355		
Inpatient days/1,000 population			1,583					

	Approved Beds		Approved Beds		
1983	6,988	1,820,925	601	141,892	636
Occupancy rate	90%		75%		85%
Inpatient days/1,000 population		1,583		355	
Beds needed	5,543		518		469*
Surplus	1,445		83		167

*Inpatient days not available for 118 beds located at Independence Sanitarium (NE Jackson County MHC), Rainbow Unit, and Bethany Hospital. 1975 occupancy rates based on 458 beds. Beds needed by 1983 is understated based on inpatient days of 94 days/1,000.

Source: Missouri Center for Health Statistics
Kansas Hospital Association

CK:elk
7/77

APPENDIX F

Table 6

TOTAL HOSPITAL BEDS - EXISTING AND APPROVED - MAHSA AREA
May, 1977

Hospital	TOTAL BEDS		MEDICAL/SURGICAL (Incl. ICU/CCU)		ICU/CCU	PEDIATRICS		OBSTETRICS		PSYCHIATRIC		ALCOHOL	
	Exist.	Appr.	Exist.	Appr.	Exist.	Exist.	Appr.	Exist.	Appr.	Exist.	Appr.	Exist.	Appr.
Cass County	50	50	38	38	-	-	-	12	12	-	-	-	-
TOTAL-CASS COUNTY	50	50	38	38	-	-	-	12	12	-	-	-	-
Liberty	130	120	124	120	6	6	0	-	-	-	-	-	-
N. Kansas City	310	355	232	275	38	20	20	16	18	24	24	18	18
Excelsior Springs	48	48	44	44	3	-	-	4	4	-	-	-	-
Spelman	128	128	107	107	5	11	11	10	10	-	-	-	-
TOTAL-CLAY COUNTY	616	651	507	546	52	37	31	30	32	24	24	18	18
Ray County	63	63	53	53	-	-	-	10	10	-	-	-	-
TOTAL-RAY COUNTY	63	63	53	53	-	-	-	10	10	-	-	-	-
Truman East	75	84	38	47	-	-	-	14	14	9	9	14	14
Plaza	8	8	8	8	-	-	-	-	-	-	-	-	-
Baptist	378	401	348	367	42	30	34	-	-	-	-	-	-
Children's	167	167	-	-	8	167	167[a]	-	-	-	-	-	-
Downtown	40	40	40	40	-	-	-	-	-	-	-	-	-
Martin Luther King	100	100	100	100	8	-	-	-	-	-	-	-	-
K.C.C.O.M.	248	426	204	382	4	20	20	24	24	-	-	-	-
Truman Medical Center	213	308	189	284	21	-	-	24	24	-	-	-	-
Independence San.	233	257	167	167	15	18	30	16	25	21	24	11	11
Lakeside	167	167	138	138	10	15	15	14	14	-	-	-	-
MCI	105	210	90	190	8	-	20	15	0	-	-	-	-
Menorah	383	430	308	357	21	27	27	22	20	26	26	-	-
N.E. Osteopathic	27	-	24	-	5	-	-	3	-	-	-	-	-
Research	521	543	404	426	26	38	38	29	29	50	50	-	-
St. Joseph	238	300	216	262	8	-	18	22	20	-	-	-	-
St. Luke's	665	665	583	583	30	30	30	52	52	-	-	-	-
St. Mary's	359	385	287	315	18	-	-	32	30	40	40	-	-
Trinity	301	361	253	313	18	18	18	-	-	30	30	-	-

Park Lane	-	110	-	110	-	-	-	-	-	-	-	-	-
John Knox Geriatric[b]	-	60[b]	-	60[b]	-	-	-	-	-	-	-	-	-
TOTAL-JACKSON COUNTY	4,228	5,022	3,397	4,149	242	363	417	267	252	176	179	25	25
Gardner	25	25	25	25	-	-	-	-	-	-	-	-	-
Olathe	100	100	90	90	12	-	-	10	10	-	-	-	-
Shawnee Mission	308	373	202	288	16	38	20	25	22	43	43	-	-
Humana	-	400	-	355	-	-	20	-	25	-	-	-	-
TOTAL-JOHNSON COUNTY	433	898	317	758	28	38	40	35	57	43	43	-	-
Cushing	94	94	84	84	-	-	-	10	10	-	-	-	-
St. John	70	70	64	64	2	-	-	6	6	-	-	-	-
TOTAL-LEAVENWORTH COUNTY	164	164	148	148	2	-	-	16	16	-	-	-	-

APPENDIX F

Table 6 (Cont.)

Hospital	TOTAL BEDS Exist.	TOTAL BEDS Appr.	MEDICAL/SURGICAL (Incl. ICU/CCU) Exist.	MEDICAL/SURGICAL (Incl. ICU/CCU) Appr.	ICU/CCU Exist.	PEDIATRICS Exist.	PEDIATRICS Appr.	OBSTETRICS Exist.	OBSTETRICS Appr.	PSYCHIATRIC Exist.	PSYCHIATRIC Appr.	ALCOHOL Exist.	ALCOHOL Appr.
K.U.	513	782	366	632	48	74	59	23	29	50	62	-	-
Bethany	379	426	276	323	14	21	21	26	26	28	28	28[c]	28[c]
Providence/St. Margaret	350	400	310	341	20	28	33	12	26	-	-	-	-
TOTAL-WYANDOTTE COUNTY	1,242	1,608	952	1,296	82	123	113	61	81	78	90	28	28
TOTAL-COMMUNITY HOSP.	6,796	8,456[d]	5,412	6,988[d]	406	561	601	431	460	321	336	71	71
V.A.-K.C.	482	482	419	419	-	-	-	-	-	63	63	-	-
V.A.-Leavenworth	448	448	277	277	-	-	-	-	-	171	171	-	-
TOTAL-FEDERAL HOSPITALS	930	930	696	696	-	-	-	-	-	234	234	-	-
Western Mo.	178	178	-	-	-	-	-	-	-	178	178	-	-
Mid-Continent	37	37	-	-	-	-	-	-	-	37	37	-	-
Rainbow Unit	60	60	-	-	-	-	-	-	-	60	60	-	-
Crittenden	-	25	-	-	-	-	-	-	-	-	25	-	-
TOTAL-PSYCHIATRIC HOSP.	275	300	-	-	-	-	-	-	-	275	300	-	-
Rehabilitation Institute	40[c]	40[c]	-	-	-	-	-	-	-	-	-	-	-
TOTAL-SPECIALTY HOSPITALS	40[c]	40[c]	-	-	-	-	-	-	-	-	-	-	-
TOTAL-HOSPITAL BEDS	8,041	9,726[d]	6,108	7,684[d]	-	561	601	431	460	830	870	71	71

[a] 22 parental self-care units, 45 bassinets

[b] Not approved by Planning Agencies

[c] Non-Acute Care

[d] Includes 60 beds at John Knox Geriatric

CK:gjh
6/77

Source: Missouri Center for Health Statistics; Kansas Hospital Association; MARSA and MACHPA Project Review Files

APPENDIX F
Table 7
HOSPITAL BEDS BY SERVICE AND OCCUPANCY RATE
1975
MAHSA HOSPITALS

Hospital	Total Licensed Beds	Total Staffed Beds	Number Discharged	ACUTE CARE: Total Acute Staffed Beds	Total Acute Occup. Rate	Med-Surg. Staffed Beds	Med-Surg. Occup. Rate	Pediatrics Staffed Beds	Pediatrics Occup. Rate	Obstetric Staffed Beds	Obstetric Occup. Rate	Psychiatric Staffed Beds	Psychiatric Occup. Rate	NON-ACUTE: Other Staffed Beds	Other Occup. Rate
CASS CO., MO.															
Local Government															
Cass Co. Mem.	50	50	1,955	50	65.8	38	79.7	-	-	12	22.1	-	-	-	-
CLAY CO., MO.															
Local Government															
Liberty	130	130	4,653	130	64.7	124	64.2	6	75.1	-	-	-	-	-	-
North KC	355	257	11,134	257	84.2	197	89.5	20	58.9	16	49.2	24	85.4	-	-
Not-for-Profit															
Excelsior Sprgs	50	50	1,581	50	55.6	44	56.8	2	77.7	4	31.2	-	-	-	-
Spelman Mem.	128	128	5,536	128	75.8	107	78.0	11	(Inc. in Med. Surg.)	10	49.8	-	-	-	-
JACKSON CO., MO.															
Local Government															
Jackson County	84	75	2,808	75	66.5	42	55.5	-	-	14	77.8	9 10b	50.4 111.5	-	-
State Government															
Western Missouri Mental Health	178	178	6,832	178	68.4	-	-	-	-	-	-	178	68.4	-	-
Federal Government															
Veteran's Hosp.		482	9,752	482	79.8*	419	79.8	-	-	-	-	63	93.3	-	-
For Profit															
Doctor's	34	34	756	34	36.3	34	36.3	-	-	-	-	-	-	-	-
Plaza	8	8	422	8	77.0	8	77.0	-	-	-	-	-	-	-	-
Not-for-Profit															
Baptist Mem.	401	378	14,327	378	82.5	348	86.4	30	37.7	-	-	-	-	-	-
Children's Mercy	167	167	5,431	167	69.6	-	-	167	69.6	-	-	-	-	-	-
Downtown	40	40	960	40	54.6	40	54.6	-	-	-	-	-	-	-	-

Hospital Beds by Service and Occupancy Rate - 1975

Hospital	Total Licensed Beds	Total Staffed Beds	Number Discharged	ACUTE CARE: Total Acute Staffed Beds	Total Acute Occup. Rate	Med-Surg. Staffed Beds	Med-Surg. Occup. Rate	Pediatrics Staffed Beds	Pediatrics Occup. Rate	Obstetric Staffed Beds	Obstetric Occup. Rate	Psychiatric Staffed Beds	Psychiatric Occup. Rate	NON-ACUTE: Other Staffed Beds	Other Occup. Rate
JACKSON CO. (Con'd)															
Not-for-Profit															
Dr. M.L. King	100	100	2,321	100	57.2	100	57.2	-	-	-	-	-	-	-	-
KC Osteopathic	426	248	9,022	248	79.7	204	84.7	20	66.6	24	46.9	-	-	-	-
KC General	224	222	7,804	222	73.9	196	74.8	-	-	26	67.5	-	-	-	-
Indep. San.	252	252	9,274*	252	74.9*	176	80.9	30	48.9	16	57.6	30	NA	-	-
Lakeside	167	167	5,275	167	67.8	138	75.9	15	33.2	14	27.5	-	-	-	-
Med. Ctr. of Independence	110	110	5,850	110	77.0	83	81.9	10	(Incl. in Med. Surg.)	17	50.2	-	-	-	-
Menorah	383	347	13,238	347	81.9	272	86.8	27	57.7	22	63.1	26	71.8	-	-
NE Osteopathic	27	27	469	27	30.2	24	31.6	-	-	3	18.5	-	-	-	-
Rehabilitation Institute	40	40	207	-	-	-	-	-	-	-	-	-	-	40a	44.7
Research	521	521	19,072	521	88.2	404	92.5	38	37.8	29	104.3	50	82.6	-	-
St. Joseph	271	215	7,447	215	76.8	180	83.7	18	31.8	17	52.4	-	-	-	-
St. Luke's	665	665	24,926	665	81.9	583	84.4	30	53.8	52	70.5	-	-	-	-
St. Mary's	385	359	11,897	359	79.9	287	80.1	-	-	32	68.2	40	87.7	-	-
Trinity	361	301	9,239	301	80.7	253	83.7	18	43.8	-	-	30	77.2	-	-
RAY CO., MO.															
Local Government															
Ray Co. Mem.	63	63	1,740	63	46.9	53	53.0	-	-	10	14.3	-	-	-	-
JOHNSON CO., KS.															
For Profit															
Gardner Com.	25	25	966	25	51.3	25	51.3	-	-	-	-	-	-	-	-
Not-for-Profit															
Mid-Continent Psychiatric	37	37	276	37	64.6	-	-	-	-	-	-	37	64.6	-	-
Olathe Com.	100	99	4,573	99	71.1	89	72.9	-	-	10	55.0	-	-	-	-
Shawnee Mission	303	241	11,038	241	86.8	187	90.3	18	64.4	22	57.1	14	115.6	-	-
LEAVENWORTH CO., KS.															
Federal Government															
VA Hospital		448	5,775	448	88.3	277	89.7					171	86.0		

*does not include psychiatric

Hospital Beds by Service and Occupancy Rate - 1975

Hospital	Total Licensed Beds	Total Staffed Beds	Number Discharged	ACUTE CARE: Total Acute Staffed Beds	Total Acute Occup. Rate	Med-Surg. Staffed Beds	Med-Surg. Occup. Rate	Pediatrics Staffed Beds	Pediatrics Occup. Rate	Obstetric Staffed Beds	Obstetric Occup. Rate	Psychiatric Staffed Beds	Psychiatric Occup. Rate	NON-ACUTE: Other Staffed Beds	Other Occup. Rate
LEAVENWORTH CO. (Cont'd)															
Not-for-Profit															
Cushing Mem.	94	94	2,837	94	55.7	84	59.1	-	-	10	16.9	-	-		
St. John	71	70	2,761	70	62.4	64	62.3			6	62.8	-	-		
WYANDOTTE CO., KS.															
State Government															
KU Med. Center	550	513	19,479	513	80.1	328	88.1	80	70.8	55	43.0	50	83.2	-	-
Rainbow Center	60	60	NA	60	NA							60	NA		
Not-for-Profit															
Bethany	389	361	11,847	333	73.8*	257	92.3	20	75.2	28	51.0	28	NA	28b	NA
Providence-St. Margaret	400	369	14,761	359	78.9	292	86.9	42	40.3	25	51.5	-	-		

	Beds Licensed	Beds Staffed	Total Acute	Med-Surg.	Pediatrics	Obstetrics	Psychiatric	Rehab.	Alcohol Treatment
Community	7,334	6,676	6,648	5,261	602	474	301		38
Specialty	40	40						40	
Psychiatric	275	275	275	____	___	___	275	—	—
TOTAL-NON-FEDERAL	7,649	6,991	6,923	5,261	602	474	576	40	38
TOTAL-FEDERAL		975	930	696			234		

Note: NA = Not Available
Others = a - Rehabilitation, b - Alcohol Treatment

Source: 1975 Health Facilities Survey, Missouri Division of Health, 1976
1975 Kansas Hospital Association Study of Hospital Utilization and Patient Origin
Missouri Hospital Directory - Missouri Division of Health
Licensed Medical Facilities in Kansas - Kansas Department of Health & Environment

CK:VP:gjh
3/31/77

APPENDIX F

Table 8

DISTRIBUTION OF APPROVED HOSPITAL BEDS (1977) AND POPULATION (1975)
MAHSA COMMUNITY HOSPITALS

Geographic Area	Population		Hospitals		Approved Beds		Beds/1,000 Population
	Total	%	Total	%	Total	%	
Platte	37,900	2.8%	0	-	-	-	-
Clay	132,300	9.8	4	12.1%	651	7.8%	4.9
Ray	18,900	1.4	1	3.0	63	.8	3.3
Northland	189,100	14.0	5	15.1	714	8.6	3.8
Leavenworth	54,900	4.1	2	6.0	164	2.0	2.9
Wyandotte	177,900	13.3	3	9.1	1,608*	19.2*	9.0
Johnson	234,100	17.4	4	12.1	898	10.7	3.8
Jackson	638,400	47.6	18	54.6	4,962	59.1	7.8
Cass	47,700	3.6	1	3.0	50	.6	1.1
Total	1,342,100	100.0%	33	100.0%	8,396	100.0%	6.26

* Includes 782 beds at KUMC. As approximately 50% of KUMC patients are from outside the Region, beds for resident population would be 6.8/1,000 for Wyandotte County and 14.5% of approved beds.

Source: Missouri Center for Health Statistics
Kansas Hospital Association
MAHSA and MACHPA Project Review Files

CK:elk
7/77

APPENDIX F

Table 9

SELECTED COMMUNITY HOSPITAL INDICATORS, 1975

	KANSAS	MISSOURI (VI)	KANSAS (VII)	WEST NORTH CENTRAL (VI)	TOTAL UNITED STATES
BASIC INDICATORS					
NUMBER OF COMMUNITY HOSPITALS	33	147	145	806	5,875
NUMBER OF BEDS	6,676	25,328	12,685	95,655	941,844
AVERAGE HOSPITAL SIZE (BEDS)		172	87	119	160
PERCENT OF U. S. BEDS		2.69 %	1.35 %	10.16 %	100.00 %
HOSPITAL BEDS/1,000 POPULATION	Exist. 5.0 App. 6.3	5.3	5.7	5.8	4.5
PHYSICIANS/100,000 POPULATION		148	138	141	149
DEMOGRAPHIC AND ECONOMIC INDICATORS					
CIVILIAN RESIDENT POPULATION (000'S)	1,342	4,738	2,240	16,604	211,445
PERCENT OF U. S. POPULATION		2.2 %	1.1 %	7.9 %	100.0 %
PERCENT OF POPULATION 65 YEARS AND OLDER	9.7%	12.6 %	12.6 %	12.2 %	10.5 %
PERCENT OF POPULATION UNDER 14 YEARS OLD		22.3 %	21.9 %	22.8 %	23.2 %
PER CAPITA INCOME		$5,387	$5,968	$5,715	$5,834
UTILIZATION INDICATORS					
PERCENT OF U. S. ADMISSIONS		2.57 %	1.26 %	9.09 %	100.00 %
PERCENT OF U. S. INPATIENT DAYS		2.73 %	1.26 %	9.60 %	100.00 %
PERCENT OF U. S. OUTPATIENT VISITS		2.10 %	1.24 %	6.45 %	100.00 %
ADJUSTED INPATIENT DAYS PER CAPITA	* 1.62	1.64	1.60	1.63	1.38
INPATIENTS					
OCCUPANCY RATE	76.4 %	76.2 %	70.4 %	70.9 %	75.0 %
ADMISSIONS/1,000 POPULATION	182.4	181	187	183	158
AVERAGE LENGTH OF STAY (DAYS)	7.65	8.2	7.8	8.1	7.7
PERCENT OF POPULATION HOSPITALIZED ON AVERAGE DAY	.38 %	0.41 %	0.40 %	0.41 %	0.33 %
INPATIENT DAYS/1,000 POPULATION	1,396	1,486	1,454	1,490	1,218
OUTPATIENTS					
OUTPATIENT VISITS/1,000 POPULATION	* 995	844	1,054	741	902
OUTPATIENT VISITS/INPATIENT DAY	* .69	0.57	0.73	0.50	0.74
OUTPATIENT VISITS/ADMISSION	* 5.46	4.65	5.63	4.05	5.70
SURGICAL OPERATIONS					
SURGICAL OPERATIONS/1,000 POPULATION	* 98.3	84.9	85.8	83.0	78.8
SURGICAL OPERATIONS/ADJUSTED ADMISSION	* .48	0.42	0.42	0.41	0.44

APPENDIX F

Table 9 (Cont.)

SELECTED COMMUNITY HOSPITAL INDICATORS, 1975

	KANSA	MISSOURI (VI)	KANSAS (VI)	WEST NORTH CENTRAL (VI)	TOTAL UNITED STATES
OPERATING INDICATORS					
ANNUAL INPATIENT TURNOVER RATE	36.8	33.94	33.09	31.76	35.50
EXPENSES					
PER CAPITA HOSPITAL EXPENSES	$ 212.47	$191.84	$164.42	$176.52	$184.26
PER CAPITA HOSPITAL EXPENSES/PER CAPITA INCOME (%)		3.56 %	2.76 %	3.09 %	3.16 %
ADJUSTED EXPENSES/INPATIENT DAY	$133	$116.74	$102.49	$108.04	$133.81
ADJUSTED EXPENSES/OUTPATIENT VISIT		$20.86	$13.85	$20.55	$22.45
ADJUSTED EXPENSES/ADMISSION		$957.07	$795.67	$878.87	$1,030.49
PAYROLL EXPENSES/TOTAL EXPENSES (%)	52.0 %	52.28 %	52.82 %	53.20 %	53.01 %
EMPLOYEE BENEFITS/TOTAL EXPENSES (%)		5.46 %	5.63 %	5.59 %	6.30 %
ADJUSTED PAYROLL EXPENSES/INPATIENT DAY		$61.03	$54.14	$57.48	$70.93
ADJUSTED NONPAYROLL EXPENSES/INPATIENT DAY		$55.71	$48.35	$50.56	$62.88
REVENUE					
GROSS INPATIENT REVENUE/INPATIENT DAY	$102.60	$125.93	$108.33	$113.44	$142.00
GROSS OUTPATIENT REVENUE/OUTPATIENT VISIT	$19.67	$23.92	$15.65	$22.71	$25.88
GROSS INPATIENT REVENUE/ADMISSION	$703.78	$1,031.58	$840.59	$923.67	$1,094.04
NET PATIENT REVENUE/TOTAL REVENUE (%)	91.88 %	90.91 %	94.25 %	92.82 %	92.02 %
GROSS OUTPATIENT REVENUE/GROSS PATIENT REVENUE (%)	8.40 %	9.74 %	9.49 %	9.05 %	11.89 %
ASSETS					
NET PLANT ASSETS/BED	* $ 55,933	$33,232.52	$31,976.03	$29,172.79	$33,226.25
ALL OTHER ASSETS/BED	* 21,517	$15,883.09	$14,373.34	$12,918.66	$16,450.65
TOTAL EXPENSES/TOTAL ASSETS	* .56	0.74	0.62	0.73	0.83
PERSONNEL					
FTE PERSONNEL/BED	* 2.81	2.40	2.14	2.11	2.52
FTE PERSONNEL/ADJUSTED AVERAGE DAILY CENSUS	* 3.16	2.83	2.77	2.71	3.00
AVERAGE YEARLY FTE WAGE	* $ 7,970	$7,876.89	$7,135.99	$7,732.56	$8,635.25
HOSPITAL EMPLOYEES AS PERCENT OF TOTAL LABOR FORCE		3.39 %	3.14 %	3.31 %	3.01 %
FACILITY AND SERVICE INDICATORS					
INTENSIVE CARE UNIT BEDS/TOTAL BEDS (%)		4.96 %	3.76 %	4.41 %	4.79 %
LONG-TERM CARE UNIT BEDS/TOTAL BEDS (%)		1.86 %	6.59 %	7.09 %	3.17 %

* *SMSA only (does not include Ray and Leavenworth)*

Source: Selected Community Hospital Indicators, 1975, American Hospital Association

APPENDIX F

Table 10

TOTAL BED NEED/SURPLUS PROJECTIONS--1983
MAHSA COMMUNITY HOSPITALS

	1983 Bed Need Projections Based on: 1975 Inpatient Days (1,396/1,000) Occupancy Rate--85%		1983 Bed Need Projections Based on: Inpatient Days (1,502/1,000) Occupancy Rate--85%	
	Need	Surplus	Need	Surplus
1982[1]	6,039	2,417	6,498	1,958
1982[2]	6,212	2,244	6,684	1,772
1982[3]	6,974	1,482	7,503	953

APPENDIX F

Table 10 (Cont.)

TOTAL BED NEED/SURPLUS PROJECTIONS--1983
MAHSA COMMUNITY HOSPITALS

	1983 Bed Need Projections Based on: 1975 Admission Rate (182.4/1,000) Length of Stay--7.65 Occupancy Rate--85%		1983 Bed Need Projections Based on: Admission Rate (200.2/1,000) Length of Stay--7.65 Occupancy Rate--85%	
	Need	Surplus	Need	Surplus
1982[1]	6,036	2,420	6,625	1,831
1982[2]	6,209	2,247	6,815	1,641
1983[3]	6,971	1,485	7,651	805

[1]No population growth (1,342,100)
[2]Increase in population based on 1970-75 trend (1,380,550)
[3]MARC projections (1,550,000)

Total beds available by January 1, 1983 - 8,456
Inpatient days - 1,502 - projection based on 1972-75 trend
Admission rate - 200.2 - projection based on 1971-75 trend

CK:gjh
9/77

Exhibit A to Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss

AFFIDAVIT OF JERRY B. BUXTON

(Filed in the United States District Court for the Western District of Missouri, Aug. 18, 1978)

(Title omitted in printing)

STATE OF MISSOURI

COUNTY OF COLE, SS:

COMES NOW JERRY B. BUXTON, of lawful age, first having been duly sworn, and states as follows:

1. I am the Director of the Insurance Division of the State of Missouri and have personal knowledge of the matters set forth herein.

2. While Chapter 354, RSMo. (1973) authorizes the Division of Insurance to regulate certain limited aspects of the activities of health service corporations, including Blue Cross, Chapter 354 does not regulate, govern or control any aspect of contracts between Blue Cross and hospitals or other health care providers in Missouri.

3. No rule or regulation promulgated by the Division of Insurance pursuant to its statutory authority regulates, governs or controls any aspect of contracts between Blue Cross and hospitals or other health care providers in Missouri.

4. No Missouri statute authorizes the Division of insurance to regulate, govern, control or review Blue Cross contracts with Missouri hospitals or other institutional health care providers. The Division of Insurance does not and cannot regulate, govern or control the terms and provisions of such contracts, rates of or conditions of reimbursement by Blue Cross under such contracts, nor entry into or termination of such contracts.

5. Chapter 355, RSMo. (1969) as amended does not regulate, govern or control any aspect of contracts between Blue Cross and hospitals or other health care providers in Missouri.

6. Chapter 374, RSMo. (1969) as amended, including without limitation Section 374.190, RSMo. (1969) does not regulate, govern or control any aspect of contracts between Blue Cross and hospitals or other health care providers in Missouri.

7. Sections 375.930, et seq., RSMo. (1978) does not regulate, govern or control any aspect of contracts between Blue Cross and hospitals or other health care providers in Missouri.

8. Chapter 376, RSMo. (1969) as amended does not regulate, govern or control any aspect of contracts between Blue Cross and hospitals or other health care providers in Missouri.

9. No provision of any of the aforementioned Missouri statutes authorize the Division of Insurance to regulate, control, govern or approve any aspect of any contract between Blue Cross and any institutional health care provider in Missouri.

10. Chapter 354, RSMo. (1973) and the rule and regulations promulgated pursuant thereto relate primarily to contracts between Blue Cross and its individual member subscribers, but the Division of Insurance has no statutory authority or power to control Blue Cross individual member subscriber contract rates.

11. The Insurance Division of the State of Missouri does not regulate, govern or control the provision or delivery of health care services to the general public by any hospital, nor any activity of any Missouri hospital or other direct

provider of health care, including, without limitation, any aspect of any hospital contract with any third party payor.

Further affiant saith naught.

/s/ JERRY B. BUXTON
Jerry B. Buxton

Subscribed and sworn to before me, a Notary Public in and for said County and State, this 1st day of August, 1978.

/s/ JACK K. RICHARDSON
Notary Public

My Commission Expires:

Sept. 19, 1981

Exhibit B to Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss

AFFIDAVIT OF HENRY MANDRO

(Filed in the United States District Court for the Western District of Missouri, Aug. 18, 1978)

(Title omitted in printing)

STATE OF MISSOURI

COUNTY OF COLE, SS:

COMES NOW HENRY MANDRO, of lawful age, first having been duly sworn, and states to the best of his knowledge and belief as follows:

1. I am the Director of the Missouri State Health Planning and Development Agency and have personal knowledge of the matters set forth herein.

2. While the Missouri State Health Planning and Development Agency has been conditionally designated under Public Law 93-641, The National Health Planning and Development Act, it is not designated as a state planning agency for purposes of 42 USCA § 1320a-1 (SSA 1122), nor is it designated as a state planning agency under any certificate of need law in Missouri pursuant to Public Law 93-641 (42 USCA § 300m-2).

3. No agency or entity in Missouri is or has been designated by any Missouri law to perform the duties and functions of a state health planning agency under Public Law 93-641 (42 USCA § 300m, et seq.).

4. Missouri's participation in the SSA 1122 Program under 42 USCA § 1320a-1 terminated June 30, 1976. Missouri does not now have nor has Missouri had since that date any contract with HEW under the SSA 1122 Program.

PREVIOUS PAGE WAS BLANK

5. Missouri does not have any certificate of need law nor any law requiring or providing for review and determination of need for new institutional health services proposed to be offered or developed within the state.

6. The Missouri State Health Planning and Development Agency does not now regulate, govern or control rates charged by Blue Cross of Kansas City to its individual member subscribers.

7. The Missouri State Health Planning and Development Agency does not now regulate, govern, control or review contracts between Blue Cross of Kansas City and its individual member subscribers.

8. The Missouri State Health Planning and Development Agency does not now regulate, govern, control or review the terms, provisions, rates of reimbursement, entry into or termination of any contract or agreement between Blue Cross of Kansas City and a Missouri hospital or other institutional health care provider.

Further affiant saith naught.

/s/ HENRY MANDRO
Henry Mandro

Subscribed and sworn to before me, a Notary Public in and for the County and State aforesaid, this 3rd day of August, 1978.

/s/ D. B. KAMMERER
Notary Public

My Commission Expires:

June 18, 1981

Exhibit C to Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss

PREREQUISITES FOR APPLICATION FOR ADMISSION AS A BLUE CROSS PARTICIPATING HOSPITAL

(Filed in the United States District Court for the Western District of Missouri, Aug. 18, 1978)

PREREQUISITES
for
APPLICATION FOR ADMISSION
as a
BLUE CROSS
PARTICIPATING
HOSPITAL

Blue Cross of Kansas City
3637 Broadway • Kansas City, Missouri 64141

Additional copies of these Prerequisites
are available on request from:
Blue Cross of Kansas City
3637 Broadway, Box 169
Kansas City, Missouri 64141

January 1, 1976

The Board of Trustees of Blue Cross of Kansas City, Missouri (hereinafter referred to as "Blue Cross") in accordance with the purposes set forth in its Articles of Incorporation, has approved the following Prerequisites upon which, after January 1, 1976, it will consider any application for a contract as a Participating Hospital.

These Prerequisites are stated in broad terms to cover basic and minimal requirements in an all-inclusive sense and from a service area point of view. The Prerequisites are declaratory, informational, solely, and are not contractual or invitational in any degree or respect.

The Prerequisites are for the purpose of:

1. Assuring hospitals which offer the area an adequate range of hospital care of high quality and at reasonable cost and which meet the stated Prerequisites and which hospitals thereafter apply for participation status.

2. Assuring Blue Cross subscribers that hospitals granted participating contracts reasonably may be deemed capable of meeting all contractual obligations as Participating Hospitals.

Blue Cross of Kansas City

PREREQUISITES

Blue Cross will be guided by the following Prerequisites in contracting with hospitals that apply for participation in its hospital service plan after January 1, 1976. However, in the interest of best serving Blue Cross subscribers and hospitals, Blue Cross reserves the right to determine in its own discretion those individual hospitals to which it may wish to tender Participating Hospital contracts. These Prerequisites do not apply to hospitals presently participating with Blue Cross.

I. APPROVAL, LICENSURE, AND CONTROL

A. The hospital shall be accredited by the Joint Commission of Accreditation of Hospitals. If in operation less than twelve months and not eligible for official accreditation, it shall present evidence satisfactory to Blue Cross of its ability to become accredited upon completion of twelve months of operation.

B. If a hospital is an osteopathic hospital, it shall be accredited by the American Osteopathic Association. If in operation less than twelve months and not eligible for official accreditation, it shall present evidence satisfactory to Blue Cross of its ability to become accredited upon completion of twelve months of operation.

C. The hospital shall be acceptable to the

medical society of the county in which it is situated. If the hospital is an osteopathic hospital, it shall be acceptable to the official osteopathic physicians association of the state in which the hospital is located.

D. The hospital must be a public hospital which has received approval from the appropriate planning agency.

E. The hospital shall comply with all applicable licensing requirements.

F. The hospital must be in actual operation.

G. The governing body of the hospital shall be responsible for the operation of the hospital, including but not limited to the quality of medical care. The governing body shall assure to Blue Cross its charges are reasonable and consistent with other similar hospitals in the community providing similar services.

H. The hospital shall be organized and staffed so as to insure accurate, complete and current maintenance of all financial and business records, and capable of promptly presenting complete financial reports as may be reasonably requested by Blue Cross. The hospital must agree to the use of a uniform classification of accounts system based on the accounting manuals of the American Hospital Association and shall have an effective system of cost accounting. The hospital shall have its certified public accountants furnish data to Blue Cross upon request.

I. The hospital shall agree to cooperate with Blue Cross in observing and fulfilling the requirements of the Member Hospital Contract and the By-Laws of Blue Cross.

J. The hospital shall not refuse admission or service to any person on the basis of race, creed, color, or national origin.

II. EVIDENCE OF NECESSITY

The hospital must meet a clearly evident need for health care services in its defined service area. Health care institutions and institutional services shall be approved, and/or if required by law, certified as necessary, by the designated planning agency or areawide health planning agency respectively; or, when effective, by the designated State Agency as provided for in Public Law 93-641, the "National Health Planning and Resources Development Act of 1974."

Blue Cross shall seek the recommendation of the appropriate health planning agencies concerning the need for the hospital, but final determination as to the tender of a contract by Blue Cross shall be at the sole discretion of Blue Cross. Because lack of knowledge by any applicant of this requirement shall not be considered sufficient reason for waiving it, community groups contemplating construction of new hospitals are urged to consult with Blue Cross, if they expect to apply for participation in the hospital service plan, at some time well in advance of actual construction.

Exhibit D to Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss

ADMINISTRATORS NEWSLETTER
From Blue Cross of Kansas City

SPECIAL NEWSLETTER TO BLUE CROSS MEMBER HOSPITALS IN MISSOURI

(Filed in the United States District Court for the Western District of Missouri, Aug. 18, 1978)

Blue Cross of Kansas City has been observing with considerable interest the events regarding the State of Missouri's cancellation of the SSA-1122 Capital Expenditure Program. It appears at this time that the final position of the Department of Health, Education, and Welfare on this matter has not been clarified with respect to reimbursement sanctions. It also appears that the State of Missouri has no intention of reinstating the State Comprehensive Health Planning Agency to perform the SSA-1122 program review.

In view of this action, the Provider Relations Committee of the Blue Cross Board of Trustees felt it necessary to advise all Missouri Member Hospitals of our position on this matter. As you are aware, the Member Hospital Contract contains a provision that capital expenditures of over $350,000 or 5% of the hospital's operating expense in the most recent fiscal year, whichever is lesser, be approved by the local or regional planning agency. Since the State Planning Agency no longer exists, Blue Cross of Kansas City will look to the local Health Systems Agency for approval of such capital projects. That Health Systems Agency in the Kansas City metropolitan area is the Mid-America Health Systems Agency and in the balance of our operating area, Area II Health Systems Agency. *All projects not reviewed and approved by these Health Systems Agencies will not be reimbursable by Blue Cross of Kansas City.*

Therefore, we urge you to continue working with these agencies and Blue Cross of Kansas City in future planning needs for your hospital. Should you have any questions regarding our position on this matter, please do not hesitate to consult with us.

/s/ GARY L. IHDE

Gary L. Ihde
Vice President
Institutional Provider Affairs

GLI: lmb

July 21, 1976

Exhibit B to Answers of Blue Cross Association to Interrogatories of National Gerimedical Hospital

APPROVAL PROGRAM FOR BLUE CROSS PLANS

(Filed in the United States District Court for the Western District of Missouri, Nov. 28, 1978)

BLUE CROSS ASSOCIATION
840 North Lake Shore Drive
Chicago, Illinois 60611

5/12/77

This booklet describes the official Approval Program for Blue Cross Plans. It supersedes all previously published statements.

As early as 1933, the concept of Prepayment for Hospital Care was endorsed and within several years thereafter a set of Approved Standards for Nonprofit Hospital Service Plans was adopted. The Approval Program has been in continuous operation ever since. During this period, on several occasions, the Approval Standards and their interpretations were strengthened and clarified.

The purpose of the Approval Program for Blue Cross Plans is to assure that standards of performance are maintained to protect the interests of the public.

The interests of the public are protected by standards which require a Plan—to include representatives of the public and hospitals on its policy-making governing board; to promote enrollment; to provide benefits which substantially cover the costs of hospital services; to achieve and maintain financial stability; to pay out at least 85 per cent of subscriber income in the form of subscriber services; to report to the public concerning its operations and its programs; to operate in such a manner that none of its net earnings shall inure to the benefit of any individual, and

to meet certain licensing requirements which permit the Plan to use the Blue Cross symbol and name which are registered by the Blue Cross Association.

Only those Blue Cross Plans which are approved by the Blue Cross Association have the right to use the words "Approved by the Blue Cross Association."

GENERAL PRINCIPLES

1. APPROVAL of the Blue Cross Association and the words "Approved by the Blue Cross Association" shall be determined by a Plan's adherence to the "standards" set forth in the following section.

2. THE INTEREST AND RESPONSIBILITY of contracting hospitals, that is, hospitals guaranteeing service, make it desirable that in addition to representatives of the general public, the Plan's governing board shall include representatives of such hospitals. It is also desirable that the medical profession be represented on the Plan's board.

3. ALL HOSPITALS IN EACH ENROLLMENT AREA that are qualified and equipped to provide the services in the Plan's subscriber certificate should have an opportunity to contract to provide these benefits. At least a majority of these hospitals should so contract. Equitable arrangements should be made for provision of benefits in non-contracting hospitals.

4. NO PLAN SHOULD BE GIVEN ORIGINAL APPROVAL whose territory does not comprise sufficient area and population to provide adequate spread of risk and efficient and economical management, with an adequate number of hospitals to assure service to subscribers.

5. PLANS SHOULD ARRANGE FOR SERVICE BENEFITS to members, rather than provide cash allowances for the purchase of hospital care.

APPROVAL STANDARDS FOR BLUE CROSS PLANS WITHIN THE UNITED STATES

1. ORGANIZATIONAL STRUCTURE

A Plan's corporate and administrative structure shall be consistent with its scope and functions, and shall be governed by a board composed of representatives of the public and providers of service.

Interpretation:

A. A majority of the Plan's governing board shall be representative of the public. A public member shall not be an employee of or have a financial interest in a health care facility or be a member of a profession which provides health care services.

B. The interests of any board member, officer, or employee of a Plan which may be in conflict with the interests of the Plan shall be disclosed to the Board.

2. AUTHORITY TO OPERATE

A Plan shall operate as a voluntary, nonprofit, community service organization.

Interpretation:

A. A Plan shall have defined community service objectives which it implements in its operations.

B. A Plan shall operate in conformance with its legal authority.

C. Trustees or board members of a Plan shall receive no remuneration for such service, nor shall any part of the net earnings of a Plan inure to the benefit of any individual.

3. BENEFITS TO MEMBERS

A Plan shall provide its members with benefits which substantially cover the costs of hospital services.

Interpretation:

A. A Plan shall cover, on behalf of all member patients, an average of not less than 75 per cent of the total amount billed for usual and customary hospital services rendered on an inpatient basis in multiple bed accommodations in contracting hospitals. There shall also be some provision for outpatient coverage.

B. A Plan shall have provided as subscriber benefits, a minimum average of 85 per cent of its earned subscriber income during the three-year period immediately preceding the current approval review.

C. A Plan's benefit shall be increased to keep pace with the development of expanded services in contracting hospitals, and to work toward comprehensiveness of benefits.

4. FINANCIAL RESPONSIBILITY

A Plan shall maintain a financial condition that adequately protects its subscribers as evidenced by reports which include a full statement of all direct and contingent liabilities as presented in an independent annual audit. A Plan's reserves should be sufficient to meet claim and operating expenses for a period of at least three months.

When a Plan's reserves are not sufficient to meet claims and operating expenses for at least three months, it shall produce satisfactory evidence to the Association that its financial policies are sound and that corrective action is being taken to achieve sufficient reserves.

5. Cost Containment Program

A Plan shall adopt and implement a cost containment program. Such program, incorporating those guidelines established by the Blue Cross Association Board of Governors, shall include a means to analyze relevant data concerning costs of health care, to make appropriate recommendations as to effectiveness and to submit reports as required to the Blue Cross Association. (Effective immediately (5/12/77) with compliance measured after January 1, 1978.)

6. Relationship With Individual Hospitals

A Plan shall have written agreements with at least 75 per cent of non-federal short-term hospitals registered by the American Hospital Association containing at least 75 per cent of these hospitals' beds in the Plan's service area, and the agreements shall include:

A definition of the responsibility of the Plan to the hospital with respect to frequency of hospital reimbursement.

A definition of the method of hospital payment.

A definition of the responsibility of the contracting hospital to the Plan with respect to servicing and guaranteeing service to members holding contracts for which the Plan assumes responsibility and the hospital's responsibility for the prudent use of its facilities and services.

A definition of the rights of the Plan and its contracting hospitals regarding the right of inspection of the records by the other party to the contract and a statement of the rights of either party to cancel or amend the contract.

Interpretation:

A Plan may adopt reasonable standards governing the acceptability of hospitals as contracting hospitals. In

the event a Plan's standards of acceptability are more stringent than the American Hospital Association standards for registration, a lesser percentage than 75 per cent may be used by the Blue Cross Association to determine compliance with this standard.

7. Accounting and Statistical Records

A Plan shall maintain such accounting and statistical records as may be reasonably required by the Board of Governors of the Blus Cross Association and shall submit such reports on the form and in the manner so prescribed.

8. Interplan Cooperation

A Plan shall participate in national programs, generally accepted by Plans.

Interpretation:

The continuing availability of hospital service benefits to large segments of the public without geographic restriction requires effective cooperation among Plans and their contracting hospitals.

9. Enrollment

A Plan's enrollment objectives shall be determined and results shall be evaluated at least annually.

Interpretation:

A. A Plan shall provide group and non-group enrollment opportunities to the people in its service area at least annually.

B. Responsibility for promotion and enrollment shall be vested in the salaried management of the Plan. An independent sales agency shall not be given responsibility for promotion and administration.

10. PUBLIC INFORMATION

A Plan shall conduct a continuing informational program to explain its functions, services, financing, and responsibilities to the public.

11. RELATIONSHIP WITH ORGANIZED GROUPS OF HOSPITALS

A Plan shall maintain close liaison with organized groups of hospitals in its area.

Interpretation:

A. The Plan representatives and the state or local hospital association representatives shall meet at least semi-annually to discuss matters of mutual interest.

B. A Plan shall participate in programs sponsored by organized groups of hospitals.

C. A Plan shall regularly exchange with organized groups of hospitals, statistical, financial or any other information of mutual interest.

12. LICENSED BY THE BLUE CROSS ASSOCIATION

A Plan shall be a licensee in good standing under an agreement with the Blue Cross Association which attests to the Plan's compliance with the standards for such licensure and permits it to use the Blue Cross symbol and name.

FAILURE TO MEET APPROVAL STANDARDS

If a Plan fails to meet the provisions of one or more of the foregoing standards, the Plan Approval Committee may recommend to the Board of Governors of the Blue Cross Association that such Plan's approval be terminated. If a Plan fails (a) to furnish such information in support of its application as may reasonably be required, or (b) to

comply with the foregoing standards, all within such period as the Board of Governors may deem reasonable, the Board of Governors may terminate its approval.

If a Plan's failure to comply with one or more of these standards results in its being notified that approval is to be withdrawn, it shall have the right, upon request to the Board of Governors of the Blue Cross Association, to present evidence of the extent to which circumstances prevent compliance.

APPROVAL REQUIREMENTS FOR ORGANIZATIONS OPERATING NONPROFIT BLUE CROSS PLANS OUTSIDE THE UNITED STATES

1. The governing board shall contain representation of the public and of hospitals from the area served.
2. No member of the governing board shall receive compensation for service as such.
3. No portion of the earnings remaining after the cost of administration has been satisfied shall inure to the benefit of any individual.
4. Subscribers shall have free choice of physician and hospital.
5. The Plan shall make available to the public benefits which shall cover at least 75 per cent of that portion of hospital expense which the Plan acknowledges it is in business to prepay.
6. Provision shall be made for benefits in out-of-area cases.
7. Finances shall not be comingled with those of any hospital.
8. No employee shall receive more than half of his compensation through commissions or on a production-fee basis.
9. Reports as to fiscal condition and membership status and such other reports as may reasonably be required shall be furnished to the Blue Cross Association upon request.
10. The Plan shall be a licensee in good standing to use the Blue Cross symbol and the words "Blue Cross."
11. The foregoing requirements shall apply except as they may be prohibited by law.

Exhibit F to Answers of Blue Cross Association to Interrogatories of National Gerimedical Hospital

COST CONTAINMENT APPROVAL STANDARD FOR BLUE CROSS PLANS AND IMPLEMENTING REQUIREMENTS AND GUIDELINES

(Filed in the United States District Court for the Western District of Missouri, Nov. 28, 1978)

Cost Containment Approval Standard

"A Plan shall adopt and implement a cost containment program. Such program, incorporating those guidelines established by the Blue Cross Association Board of Governors, shall include a means to analyze relevant data concerning costs of health care, to make appropriate recommendations as to effectiveness and to submit reports as required to the Blue Cross Association."

Cost Containment: Meaning

The term "cost containment" has been widely used for a number of years. To assure a common understanding of the intent of the Approval Standard, and related materials which follow, a brief description of the term is in order.

With respect to Blue Cross Plan operations, containment of costs has two dimensions: (1) savings which can be obtained through internal productivity and administrative efficiencies and, (2) savings and/or cost avoidance of benefit payments made to providers.

The Standard is not directed at the first dimension noted above, i.e. sound internal business practices, efficient and timely claims processing, prudent buyer concept and the like. BCA monitoring and evaluation efforts of this aspect of Plan cost containment have been in effect through the existing Plan Performance Standards and the Total Plan Review program.

PREVIOUS PAGE WAS BLANK

The Standard, therefore, pertains to the second dimension of cost containment, maximizing the value of subscriber premiums employed as benefit payments. This dimension has two components. The first relates to those Plan activities which primarily accrue savings to Blue Cross Plan subscribers as opposed to all purchasers of care. Examples of such activities are coordination of benefits, determination of other payer liability and establishment and maintenance of an appropriate price differential relative to other payers.

The second component of benefit payment containment efforts consists of those initiatives associated with the the broader social, rather than traditional insurer, objectives of the Blue Cross movement. Plan involvement in incentive provider payment systems, health planning, utilization review, health education and innovative health care benefit programs are examples of this second component—the "value added" by Blue Cross Plans. This is accomplished by working with providers, government and other external entities to effectively contain total health care costs while assuring reasonable access to quality health care.

Requirements to Meet the Standard

In order to determine compliance with the Standard, there are requirements which constitute the minimum Plan cost containment activities. Presented below, under the categories of "structural" and "programmatic," are requirements for all Blue Cross Plans.

Structural Requirements

1) A data base which measure and evaluates at least annually, based on historical trends, regional or other comparisons, etc., the following six indices:

Hospital Inpatient Cost/member
Hospital Inpatient Cost/admission
Hospital Admissions/1000 members
Hospital Patient Days/1000 members
Hospital Acute Care Beds/1000 population
Hospital Acute Care Bed Occupancy Rates

It is highly desirable that these indices representing total Plan area averages, and any others that the Plan determines meaningful (e.g., outpatient cost per member, outpatient visits/1000 members, FTE hospital personnel per patient day, professional ancillary costs per admission, etc.), be disaggregated in as much detail as practicable and useful (by individual hospital, diagnosis, geographic area, type of hospital personnel, type of acute care bed or service category, major account, etc.) to enable the Plan to adequately identify cost problems and plan, monitor and evaluate cost containment programs and activities as solutions to these problems.

In addition, each Plan should regularly collect data on the number of physicians per 1000 population (preferably by specialty) and analyze this information in concert with the above indices.

2) An annual set of quantified objectives related to at least each of the six indices.

3) A plan of action for each objective which describes those specific projects and activities (with corresponding resource requirements-administrative costs) designed to achieve the objectives.

4) A monitoring, reporting and evaluation system designed to measure progress of the action plan and achievement of the objectives.

5) An annual report to the Blue Cross Association which presents the objectives and action plan with estimated and actual results.

Programmatic Requirements

The following fundamental programmatic initiatives are required of each Plan:

1) An active program of fraud and abuse investigation.

2) An internal, multi-level claims utilization review screening, evaluation and reporting system with respect to medical necessity and appropriateness of hospital inpatient stays and services rendered.

3) Educational programs directed at individual subscribers, groups and providers stressing prevention of unnecessary and inappropriate use of health care services.

4) Active coordination of benefits and subrogration programs if legally possible; an active legislative goal of making such programs legally possible, if necessary.

5) An active program of subscriber benefit eligibility determination and identification of non-covered services which have been billed to the Plan.

6) Participation in selected health planning activities, such as Plan representation on health planning agency governing bodies and/or standing committees, Plan data support or technical consultation to agencies relative to health plan development, evaluation of specific provider capital projects, etc.

7) Periodic exploration of incentive approaches for paying participating hospitals, such as prospective payment systems.

Beyond the basic programmatic requirements listed above, there are a variety of other programs or processes that represent options for Plan consideration, based on its local circumstances. Presented below in three categories is a non-exhaustive listing of such processes. From a practical standpoint, a given process may be viewed as falling within more than one category. In addition, processes in

any given category may vary in terms of the extent of savings which accrue to Blue Cross subscribers versus other purchasers of care and the general public.

1) Processes that a Plan can undertake with generally little or no active participation and concurrence of the provider community. These processes will tend to neither present direct and immediate economic risk for subscribers or providers, nor require contractual or legislative changes:

   —Internal analysis and comparison of available cost-price information on providers, from a reasonableness/efficiency standpoint;

   —Initial feasibility study of innovative benefit programs which bear some potential for cost containment, e.g., home care, second opinion surgery, ambulatory/same day surgery, preadmission or early testing, etc.;

   —Initial feasibility study of alternative delivery system programs, such as HMOs.

2) Processes that a Plan can undertake which require fairly active participation and acceptance by the provider community or subscribers, but which will tend to neither present direct and immediate economic risk for subscribers or providers nor require contractual or legislative changes, e.g.;

   —Utilization review educational/consultative support programs for providers, such as sharing UR profile information related to patterns of practice for individual hospitals and physicians compared to their peers;

   —Latter stages of planning and development of HMOs, prospective or other incentive payment features, or innovative health care benefit programs;

—Front-end consultative assistance to individual providers or geographic groupings of providers relative to their development of long-range institutional plans or specific capital project or service change proposals;

—Voluntary initiatives to reduce existing excess provider operating capacity, such as joint Plan/provider task forces to identify the nature and extent of excess capacity by type of service and geographical area and to study means, including financial and other considerations, towards its reduction or elimination;

—Provision of management consulting services, such as management engineering, to individual providers;

—Development and implementation with providers of patient health education programs.

3) Processes that a Plan can undertake which require a high level of concurrence by the provider community or subscribers and which tend to present economic risk for providers or subscribers, usually necessitating contractual or legislative changes;

—Negotiation and enforcement of contract provisions related to medical necessity and appropriateness of services rendered, guaranteed/non-guaranteed UR status, and/or hold-harmless programs;

—Negotiation and implementation of provider UR concurrent review contractual program requirements;

—Negotiation and enforcement of health planning conformance clauses in provider contracts or reimbursement agreements;

—Negotiation and implementation of prospective or other incentive payment agreements with providers;

—Testimony on proposed certificate of need legislation relative to such issues as providers, capital expenditures, and service changes to be covered, parties permitted to appeal CON decisions, legal sanctions for noncompliance with CON decisions, etc.;

—Testimony or statements at health planning agency public hearings, or appeals, related to specific provider capital project proposals;

—Negotiation and implementation with providers of alternative delivery system such as HMOs;

—Study and negotiation with providers of a differential pricing arrangement based on the Plan's appropriate share of an institution's economic costs;

—Negotiation and implementation of provider risk management programs related to malpractice coverage;

—Design and implementation of any cost-sharing features, e.g., deductibles or co-payment, in subscriber benefit programs.

To the extent practicable, ways of measuring the success or impact of these processes will be suggested by the Blue Cross Association (e.g., dollars and days of claims identified as misuse and/or denied in the claims UR screening program; portion of HSAs in the Plan area where the Plan is represented on governing bodies and/or key standing committees, unnecessary provider capital expenditures avoided as a result of Plan positions in health planning agency review or appeals processes, etc.)

Implementation of the Approval Standard

It is recognized that Plans must have sufficient time to meet all the requirements specified in this document. While effective immediately, compliance will be measured after January 1, 1978 as part of the Annual Approval Program.

The Blue Cross Association is developing a cost containment evaluation methodology/self audit manual as a guide to assist Plans as they develop their programs to comply with the Standard and accompanying requirements. The Association will also provide technical and consultative support upon request.

The Blue Cross Association's monitoring and evaluation of Plan compliance will utilize the following mechanisms:

1. The Approval Program for Blue Cross Plans.
2. The Total Plan Review program.
3. An integrated set of reporting requirements for Plans.

Exhibit J to Response of National Gerimedical Hospital to Order to Show Cause and Preliminary Suggestions of National Gerimedical Hospital Opposing Summary Judgment

AFFIDAVIT OF DAVID J. MASCHGER

(Filed in the United States District Court for the Western District of Missouri, Oct. 22, 1979)

(Title omitted in printing)

STATE OF MISSOURI,

COUNTY OF JACKSON, SS:

COMES NOW DAVID J. MASCHGER, of lawful age, first having been duly sworn, and states as follows:

1. I am the Administrator of National Gerimedical Hospital, d/b/a Lee's Summit Community Hospital and am authorized to make this Affidavit on its behalf.

2. National Gerimedical Hospital regularly purchases medication and other hospital supplies from numerous sources outside the State of Missouri.

3. National Gerimedical Hospital's primary financing has been obtained through a national bond issue underwritten by B. C. Ziegler and Company, West Bend, Wisconsin 53095.

4. National Gerimedical Hospital regularly receives third party cost and charges reimbursement from numerous sources outside the State of Missouri.

5. The day to day business of National Gerimedical Hospital is managed pursuant to a management contract by HCA Management Company, Inc., a division of Hospital Corporation of America, One Park Plaza, Nashville, Tennessee, a national and international hospital management firm.

6. National Gerimedical Hospital is a short term acute care facility which regularly offers and has regularly provided to date health care to Missouri and out-of-state patients.

7. Physicians on the medical staff of National Gerimedical Hospital have and continue to experience difficulty admitting their Blue Cross patients who are unwilling to accept admission to National Gerimedical Hospital because it is not a Blue Cross participating hospital.

8. Members of the general public have avoided and continue to avoid admission as patients at the National Gerimedical Hospital because it is not a Blue Cross participating hospital.

9. Individual Blue Cross member subscribers actually receive less Blue Cross reimbursement and have less Blue Cross coverage for medical care provided by National Gerimedical Hospital than they have for identical medical care received at a Blue Cross participating hospital.

I have read the above and foregoing and the information therein set forth is true and correct according to my best knowledge, information and belief.

Further affiant saith naught.

/s/ David J. Maschger
David J. Maschger

Subscribed and sworn to before me, a Notary Public in and for said County and State, this 23rd day of October, 1979.

/s/ Janice B. Thompson
Notary Public

My Commission Expires:
Feb. 22, 1983

Exhibit K to Response of National Gerimedical Hospital to Order to Show Cause and Preliminary Suggestions Opposing Summary Judgment

LETTER FROM GARY L. IHDE TO NATIONAL GERIMEDICAL HOSPITAL

(Filed in the United States District Court for the Western District of Missouri, Oct. 22, 1979)

3637 Broadway
P.O. Box 169
Kansas City, Missouri 64141

March 27, 1978

Mr. Gunter H. Stein
Administrator
National Gerimedical Hospital and
Gerontology Center
P.O. Box 767
Lee's Summit, Missouri 64063

Dr. Mr. Stein:

The Blue Cross Board of Trustees has reviewed your amended application for a Member Hospital Contract, as included in correspondence from James Beck dated February 15, 1978. The Board of Trustees also reviewed the letters of support for the institution as appended to the above referenced application.

After deliberation, the Board of Trustees voted unanimously at the Blue Cross Board meeting of March 21, 1978 to deny Blue Cross Member Hospital status to the National Gerimedical Hospital and Gerontology Center because your institution did not receive approval through the health planning process. As we had discussed with you prior to the submission of the application, health planning approval is a stated prerequisite as contained in the booklet, "Prerequisites for Application for Admission

as a Blue Cross Participating Hospital," and must be complied with prior to receiving Member Hospital status.

We will discuss this action by the Board with you should you desire.

Sincerely,

/s/ GARY L. IHDE
Gary L. Ihde, Vice President
Institutional Provider Affairs

GLI:mh

cc: James Beck
B. Kent Snapp

IN THE
UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MISSOURI
WESTERN DIVISION

No. 78-0359-CV-W-3

NATIONAL GERIMEDICAL HOSPITAL
AND GERONTOLOGY CENTER,
Plaintiff,

VS.

BLUE CROSS OF KANSAS CITY, *et al.*,
Defendants.

ORDER

(filed November 2, 1979)

On May 23, 1978, plaintiff, National Gerimedical Hospital and Gerontology Center (hereinafter referred to as National Gerimedical) filed a complaint against Blue Cross of Kansas City and Blue Cross Association alleging violations of the antitrust provisions of state and federal statutes.

Count I of the complaint alleges that the defendants and various named co-conspirators have engaged in a conspiracy in restraint of trade in violation of § 1 of the Sherman Act, 15 U.S.C. § 1. Plaintiff alleges in Count II that the defendants engaged in a continuing combination and conspiracy to boycott National Gerimedical in violation of § 1 of the Sherman Act, 15 U.S.C. § 1. Count III alleges that defendant Blue Cross Association and Blue Cross of Kansas City and their co-conspirators have combined and conspired in a continuous combination and conspiracy to boycott plaintiff hospital and coerce all Blue Cross subscribers to refuse to deal with plaintiff, in violation § 1 of the Sherman Act, 15 U.S.C. § 1, Count IV alleges that the defendants' actions were an effort to control market entry and dictate terms of access to the health care services mar-

ket and constitute an unlawful abuse of monopoly power in violation of § 2 of the Sherman Act, 15 U.S.C. § 2. Counts V through VIII allege violations of similar provisions of the state antitrust laws, Missouri Revised Statutes § 416.031-1 through § 416.031-2.

On July 14, 1978, defendant Blue Cross Association and defendant Blue Cross of Kansas City filed motions to dismiss plaintiff's amended complaint. After considering the parties' suggestions in support and in opposition thereto, the Court refrained from deciding the issues raised by the motion to dismiss pending the Supreme Court's decision in *Group Life and Health Ins. Co.* v. *Royal Drug Co.* Subsequent to the Supreme Court decision in that case on February 27, 1979, the parties have briefed the issue of the application of that case to the present facts. The defendants base their motion to dismiss the federal causes of action on essentially four grounds: (1) The conduct complained of is exempted from the antitrust laws by the provisions of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015; (2) the National Health Planning & Resource Act of 1974 impliedly repealed the antitrust laws where the challenged conduct is necessary to effectuate the purpose of the Act; (3) plaintiff's complaint does not allege any ultimate facts to support a claim that the defendants engaged in a conspiracy within the meaning of the antitrust laws; and (4) prepaid medical plans offered by not-for-profit corporations are not "trade or commerce" within the meaning of the Sherman Act. Additionally, the defendants argue that if the federal claims are dismissed for lack of jurisdiction, the Court should exercise its discretion and dismiss the pendent state claims.

In an order issued October 11, 1979, this Court indicated that because it was considering matters outside the pleadings presented by the parties, it would treat the motion to dismiss as one for summary judgment in accordance with Rule 12(b)(6) of the Federal Rules of Civil Procedure. The parties were given an opportunity to present additional

evidence or to oppose this action. All parties have indicated that they have no further evidence to present and do not oppose this treatment by the Court.

Rule 56(c) provides in part that summary judgment should be granted when:

> . . . the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.

It is well established that in considering a motion for summary judgment, the Court examines the evidence not to decide issues of fact but to determine if any real issues exist. *Krupin* v. *United States,* 439 F. Supp. 440 (E.D. Mo. 1977); *Bazzano* v. *Rockwell International Corp.,* 439 F. Supp. 1167 (E.D. Mo. 1977). The existence of some disputed facts in a case does not necessarily preclude the Court from granting summary judgment. To preclude summary judgment, the disputed facts must be material and of the type that would affect the outcome of the litigation. *Hahn* v. *Sargent,* 523 F.2d 461, 464 (1st Cir. 1975). Where legal questions of statutory construction involving legislative history and policy are concerned, summary judgment is an appropriate mechanism for disposing of these issues. *Mobil Oil Corp.* v. *Federal Energy Adm.,* 566 F.2d 87, 91-2 (T.E. App. 1977).

The Eighth Circuit has consistently recognized that summary judgment is an extreme remedy which should not be granted unless the movant establishes his right to judgment with such clarity as to leave no room for controversy. *Ledwith* v. *Douglas,* 77-1463, (January, 1978); *Unlaub Co.* v. *Sexton, Inc.,* 77-1293 (8th Cir. 1977).

In considering this motion the Court must view the facts most favorably to the party opposing the motion and give that party the benefit of any reasonable inferences to be

drawn from the facts. *Ledwith*, supra; *Unlaub*, supra; *New England Mutual Life Ins. Co.* v. *Null*, 554 F.2d 896, 906 (8th Cir. 1977). From all of the pleadings the Court has reviewed, it would appear that there is no material dispute as to the following facts which are a summary of the essential allegations of plaintiff's complaint by Blue Cross of Kansas City:

1. Plaintiff is a Missouri not-for-profit corporation which will open a *new* hospital on or about July 30, 1978 (Paragraph 3, Complaint);

2. Defendant Blue Cross of Kansas City is a Missouri not-for-profit Health Service corporation which offers private individual and group health care reimbursement plans and programs to the general public in Missouri and Kansas, and which contract with member hospitals and other health service provides for the administration of its health care reimbursement plans (Paragraph 4, Complaint);

3. Blue Cross is a major provider of private health care plans in Western Missouri and Eastern Kansas (Paragraph 13, Complaint);

4. All acute general care hospitals except plaintiff in the Blue Cross service area have contracted with Blue Cross and thus are "participating" hospitals. (*Ibid.*);

5. Blue Cross reimburses its individual subscribers for 100% of all covered hospital services, by direct payment to the hospital, for services at a participating hospital (*Ibid.*);

6. Blue Cross subscribers receive payment for 80% of covered hospital services performed at a non-participating hospital, which reimbursement is paid directly to the subscriber, not the hospital (*Ibid.*);

7. Blue Cross denied plaintiff a participating Member Contract solely because plaintiff failed to demonstrate a need for its hospital (Paragraph 17, Complaint);

8. Among the "Prerequisites" for membership in Blue Cross, was the requirement that a hospital "meet a clearly evident need for health care services in its defined service area." (Paragraph 18, Complaint);

9. In order to determine "clearly evident need" Blue Cross designated Mid-America Health Systems, Inc. ("MAHSA") a not-for-profit, non-governmental organization, engaged in the voluntary evaluation of health care services in Missouri and Kansas as the agency to conduct "need review" (Paragraphs 6 and 18(a), Complaint);

10. Blue Cross will not contract with any hospital as a "participating member hospital without MAHSA approval of need" (Paragraph 18(a), Complaint);

11. MAHSA has no power to impose sanction to enforce its determinations nor to compel review (Paragraph 18(b), Complaint);

12. MAHSA has publicly stated that it will disapprove and not consider favorably the addition of any acute care hospital beds.

Plaintiff's answers to interrogatories clarify one point. National Gerimedical Hospital's initial application to become a Blue Cross member hospital was made October 4, 1977 and was amended and resubmitted on February 15, 1978. (See Plaintiff's answer to Interrogatory No. 9, Ex. D.) On March 21, 1978 National Gerimedical Hospital was denied member status because it had not received approval through the voluntary health planning process. National Gerimedical has indicated that it never sought review by Mid-America Health Systems Agencies. (See Plaintiff's

answer to defendant's interrogatory No. 16, Ex. F.) Thus this is not a situation where Mid-America Health Systems has refused to issue a certificate of need to National Gerimedical Hospital, but rather plaintiff is challenging the policy of Blue Cross requiring them to seek Mid-America Health Systems' approval.

Application of McCarran-Ferguson Act

§ 2 of the McCarran-Ferguson Act, 15 U.S.C. § 1012(a) and (b) provides in part:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, . . . *Provided,* That, after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

In essence this Act has been interpreted to exempt the application of the antitrust laws from the business of insurance if it is regulated by the state and if the challenged action does not involve a boycott, coercion or intimidation. In determining the initial applicability of the McCarran-Ferguson Act, two questions must be answered: (1) are the defendants engaged in "the business of insurance" and (2) is the challenged conduct regulated by state law? In order for the activity to be exempt from the application

of the antitrust laws, both of the above criteria must be satisfied.

The briefs of Blue Cross of Kansas City and Blue Cross Association submitted in July of 1978 cited numerous case decisions holding that hospital-provider contracts are the business of insurance, regulated by state law, and thus exempt from application of the antitrust laws. Had the Court been deciding this issue prior to February 27, 1979, it would have adopted the rationale of these decisions and found that hospital payments and subscriber rates were so interrelated that Blue Cross contracts with hospitals were a part of the business of insurance. Additionally, the Court would have found that the requirements of state regulation of the business of insurance had been met. However, the Court believes that in light of the language used by the Supreme Court in *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 59 L.Ed.2d 261 (1979) the rationale of these earlier circuit opinions is no longer valid.

In *Royal Drug* eighteen owners of independent pharmacies sued Blue Shield of Texas. Blue Shield offers insurance policies on prescription drugs. If an individual covered by one of these policies utilizes a pharmacy which has entered into a "pharmacy agreement" with Blue Shield, the insured pays $2.00 and the remainder of the prescription price is paid by Blue Shield. If the pharmacy selected is a non-participating pharmacy and has not signed such an agreement with Blue Shield, the individual must pay the full price charged for the drug by the pharmacy. The insured can then obtain a reimbursement for 75% of the difference between the price charged minus $2.00. Under the agreement Blue Shield agreed to reimburse a participating pharmacy for the pharmacy's cost of acquiring the drug plus the $2.00 paid by the individual. Thus only pharmacies that could afford to distribute prescription drugs for less than the $2.00 markup could profitably participate in the plan. In determining if the contract between Blue Shield and the pharmacies was exempt from the ap-

plication of the antitrust laws because of the McCarran-Ferguson Act, the Court identified one of the primary elements of an insurance contract as the spreading and underwriting of the policyholder's risk. Petitioners in the *Royal Drug* case argued that these pharmacy agreements did involve the underwriting of risk. Although the Court recognized that some type of provider agreement will be necessary for the existence of a service benefit plan, the Supreme Court was unwilling to infer that because an agreement is necessary to provide insurance, it is also "the business of insurance." *Royal Drug,* supra at 270 ftn. 9. In rejecting this argument, the Court found:

> The fallacy of the petitioners' position is that they confuse the obligations of Blue Shield under its insurance policies, which insure against the risk that policyholders will be unable to pay for prescription drugs during the period of coverage, and the agreements between Blue Shield and the participating pharmacies, which serve only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations.
>
> • • • The Pharmacy Agreements thus do not involve any underwriting or spreading of risk, but are merely arrangements for the purchase of goods and services by Blue Shield. By agreeing with pharmacies on the maximum prices it will pay for drugs, Blue Shield effectively reduces the total amount it must pay to its policyholders. The agreements thus enable Blue Shield to minimize costs and maximize profits. Such cost savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the "business of insurance."
>
> The Pharmacy Agreements are thus legally indistinguishable from countless other business arrangements that may be made by insurance companies to

keep their costs low and thereby also keep low the level of premiums charged to their policyholders. *Royal Drug*, supra at 269-270.

Another reason for rejecting the claim that these contracts involved the business of insurance was the fact that the contracts in the the *Royal Drug* case were not between insurer and insured but were separate contractual arrangements between Blue Shield and the pharmacies engaged in the sale and distribution of goods and services other than insurance. The Court stated:

> At the most, the petitioners have demonstrated that the Pharmacy Agreements result in cost savings to Blue Shield which may be reflected in lower premiums if the cost savings are passed on to policyholders. But, in that sense, every business decision made by an insurance company has some impact on its reliability, its ratemaking, and its status as a reliable insurer. The manager of an insurance company is no different from the manager of any enterprise with the responsibility to minimize costs and maximize profits. If terms such as "reliability" and "status as a reliable insurer" were to be interpreted in the broad sense urged by the petitioners, almost every business decision of an insurance company could be included in the "business of insurance". Such a result would be plainly contrary to the statutory language, which exempts the "business of insurance" and not the "business of insurance companies." *Royal Drug*, supra at 271-272.

Defendants have attempted to distinguish the *Royal Drug* case on the grounds that the provider contract involved here contain the indispensable characteristic of insurance, i.e., the underwriting and spreading of risk. In support of this argument, the defendants suggest:

> Under the provider contract Blue Cross agrees to reimburse hospitals for services rendered to its subscrib-

> ers *only so far as current earned income will permit.* (Article IVA, Provider Contract). Unless provisions for all expenses and allocations to reserves have been each month, earned income cannot be used to pay hospitals (Article IVC, IVD). If Blue Cross does not have sufficient funds to pay benefit payments in full to hospitals, each of the provider hospitals is to receive only a portion of the benefit payments on a pro rata basis from Blue Cross. [pp. 3-4, Reply of Blue Cross of Kansas City To Supplemental Suggestions of National Gerimedical Hospital in Opposition to Defendants' Separate Motions to Dismiss filed April 9, 1979.]

Were the Court to agree with defendants' interpretation of the contract, it is doubtful if *Royal Drug* would be sufficiently distinguished to render its holding inapplicable. However, the Court's interpretation of the provider contract in this case is not totally in accord with the defendants. Atricle IVB does require reserves to be maintained by Blue Cross sufficient to provide for three months operating expenses and benefits for hospital services. After provisions for reserves have been made, benefit payments each month are to be made to the hospitals equal to the amount of benefits due for all claims processed by Blue Cross. If sufficient funds are not available, adjustment on a pro rata basis is to be made; however, Article 4D provides:

> D. If benefit payments to HOSPITAL for Hospital Service are reduced because of the application of Article IV, C above, BLUE CROSS agrees to pay pro rata the amount of such reduction to all hospitals as current earned income becomes available for such purpose.

Thus, the risk of nonpayment does not fall on the hospital as the defendants suggest, but payment is eventually to be made as funds become available on a pro rata basis.

Comparison of the Blue Cross provider contracts in this case and the Blue Shield pharmacy agreements in *Royal* have convinced the Court that no rational basis for distinguishing these contracts exist. Further, the language of the Supreme Court seems to clearly imply that such distinctions should not be drawn and would be looked on with disfavor.

> If agreements between an insurer and retail pharmacists are the "business of insurance," because they reduce the insurer's costs, then so are all other agreements insurers may make to keep their costs under control—whether with automobile body repair shops or landlords. Such agreements would be exempt from the antitrust laws if Congress had extended the coverage of the McCarran-Ferguson Act to the "business of insurance companies". But that is precisely what Congress did not do. *Royal Drug*, supra at 281.

The Supreme Court went on to add:

> There is no principled basis upon which a line could rationally be drawn that would extend the McCarran-Ferguson Act exemption only to an insurer's agreement with providers of goods and services to be furnished to its policyholders—such as agreements with hospitals, doctors, lawyers and the like. But assuming that such a line could rationally be drawn, to hold that even such provider agreements are the "business of insurance" is to ignore the language and purpose of the Act not to exempt the insurance industry as such from the antitrust laws. *Royal Drug*, supra at 281.

Therefore, defendants' motions for summary judgment on the basis that the conduct in this case involved "the business of insurance" and is thus exempt from the antitrust laws under the McCarran-Ferguson Act must be denied.

Implied Repeal of The Antitrust Laws

Secondly, the defendants have moved to dismiss the federal causes of action on the grounds that the National Health Planning and Resource Development Act of 1974 impliedly repealed application of the federal antitrust laws in the instant case. The doctrine of implied immunity or implied repeal of the antitrust laws is a judicially created exemption from the application of the antitrust laws which has been utilized to resolve potential conflicts between federal or state regulatory schemes and the antitrust laws. The Supreme Court has indicated that implied immunity has been adopted and applied:

> [I]mplied immunity [has been found] in particular and discrete instances to assure that the *federal agency* entrusted with regulation in the public interest could carry out that responsibility free from the disruption of conflicting judgments that might be voiced by courts exercising jurisdiction under the antitrust laws.

A number of well established principles can be derived from cases that have considered this doctrine. First, any immunity from the antitrust laws should not be lightly implied and repeal by implication is not favored. *Gordon* v. *New York Stock Exchange*, 422 U.S. 659, 95 S.Ct. 2598, 45 L.Ed.2d 463 (1975); *U.S.* v. *American Telephone & Telegraph Co.*, 427 F. Supp. 57 (E.D. La. 1976). In considering a claim of implied repeal of the antitrust laws, the Court should first attempt to reconcile the operation of the antitrust laws and the regulatory statutes. *Essential Communication* v. *American Telephone & Telegraph*, 446 F. Supp. 1090 (D.N.J. 1978). If reconciliation is not possible, for the reason that a clear repugnancy exists between the statutes or the particular provisions at issue and the antitrust laws, then an exemption may be created; however, the antitrust laws should be repealed only to the extent necessary to make the regulatory statute effective and then only

to the minimum extent needed. *Gordon, supra* at 479. *Mount Hood Stages* v. *Greyhound,* 555 F.2d 687 (9th Cir. 1977); *Oahu Gas Service, Inc.* v. *Pacific Resources, Inc.,* 460 F. Supp. 1359 (D.Ha. 1978); *Cavanagh Communities Corp.* v. *New York Stock Exchange,* 422 F. Supp. 385 (S.D. N.Y. 1976); see Application of Federal Antitrust Laws as Affected by Other Federal Statutes or the Federal Constitution, Annotation 45 L.Ed.2d 841.

After determining a conflict exists, the Court must also consider the manner in which Congress envisioned the conflict to be resolved. Therefore, the Court is faced with two issues in determining the effect of the National Health Planning and Resource Development Act of 1974. First, is there a conflict between this legislation and the antitrust laws. Secondly, how should that conflict be resolved.

In resolving the first issue, the Court must examine the 1974 National Health Planning and Resource Development Act. This Act was essentially composed of four parts: First, National Health Planning and Development, 42 U.S.C. § 300k through 300n-5; second, assistance for construction and modernization of health facilities; third miscellaneous provisions on the transition to the new program; and fourth, the Radiation, Health & Safety Act of 1974 amending the Public Health Service Act in this area. See Volume 4, U.S. Code Cong. & Adm. News (1977) p. 7842. The only portion of the Act with which the Court is concerned in this case is Subchapter XIII entitled "National Health Planning and Development".

The National Health Planning and Development portion of the Act established national health priorities. The Secretary of HEW was directed to issue guidelines concerning national health planning goals after considering the national health priorities established by Congress in this section of the Act. Two goals that were established by the Act and of special concern to Congress as evidenced in the

Act and in its accompanying legislative history were: (1) reduction of hospital costs; and (2) elimination of unnecessary duplication of health care facilities. The Secretary was also directed to set standards concerning the appropriate supply, distribution and organization of the nation's health resources. See 42 U.S.C. § 300k-1 through 300k-2. The National Advisory Council on health planning and development was established to advise and consult with HEW and to make recommendations to that department concerning the development of appropriate guidelines. 42 U.S.C. § 300k-3.

The Act provided for the establishment of health service areas in accordance with a number of very specific requirements set forth in 42 U.S.C. § 300*l*. To service these areas, health systems agencies were to be established in each health system area. These agencies were given responsibility for health planning and resource development in their particular area. 42 U.S.C. § 300*l*-2(b). Each health systems agency was to adopt a health service plan and an annual implementation plan. The functions assigned to the health service area were to effectuate the purposes of: (1) improving the health of the residents of their area; (2) increasing accessibility, acceptability and quality of the health services provided in their area; (3) restraining increases in the cost of health care; and (4) preventing unnecessary duplication of health resources. 42 U.S.C. § 300*l*-2. Procedures were also established for a state health planning and development program. The Act further provided that to implement the health service plan and the annual implementation plan, the Health Service Agency should seek the assistance of individuals, public and private entities, in its health service area. See 42 U.S.C. § 300*l*-2(c)(1). It thus appears that the Act authorized and anticipated that the health service agency established by its provisions would consult and work with private health care providers to attempt to achieve voluntary cooperation with the goals of the agency and of the Act.

Mid-America Health Systems Agency was one of 205 regional health systems agencies established under the Act and conditionally designated as the health planning body for the eight county bi-state area encompassing the counties of Cass, Clay, Jackson, Platte and Ray in Missouri and Johnson, Levenworth and Wyandotte in Kansas. In November of 1977 Mid-America Health Systems established a health systems plan for 1978 through 1982 in this region. Increasing hospital costs and unnecessary duplication of facilities and equipment were considered two of the biggest problems in this region. The health systems plan adopted by Mid-America Health Systems recognized:

> Problem—The acute inpatient care system does not function in a coordinated manner which is cost-effective in the delivery of acute care services at the most appropriate level consistent with quality standards. (Health Systems Plan at p. 6-19.)

The goal in this area was recognized as:

> *Goal:* Improve the health of the population in the MAHSA area through an adequately available and accessible acute inpatient care system coordinated in a manner that fosters containment of health care costs and provides quality of care in a culturally acceptable manner. (Health Systems Plan at p. 6-19.)

To implement this goal MAHSA established a number of objectives in this area and specified particular methods that could be utilized to achieve each objective. Objective No. 4 seeks to:

> *Objective #4*
>
> Maintain a rate of increase in total expenditures for hospital care services which does not exceed the rate of increase in the medical care services component of the Consumer Price Index. (Health Systems Plan at p. 6-21.)

As one of the nine methods set forth to meet this goal, Mid-America Health System suggested:

> (6) Third party payors and the hospital community should work together to develop uniform reporting systems and procedures such that meaningful hospital-to-hospital and year-to-year hospital cost and service-by-service utilization comparisons can be made. (Health Systems Plan at p. 6-22.)

The certificate of need requirement voluntarily adopted by Blue Cross of Kansas City seems to be authorized by the Act as well as the implementation plan of MAHSA.

In determining if an exemption to the antitrust laws can be implied, courts have distinguished two types of exemptions—specific and blanket. A specific repeal of the antitrust laws implies an exemption only for particular conduct or activity. An exemption for an entire legislative scheme would be a blanket exemption. Courts that have upheld claims of implied repeal have normally limited this repeal to the specific conduct challenged in that particular case; however, in the circumstances of this case defendant's claim is that the entire concept of the National Health Planning and Resource Development Act presupposes non-application of the antitrust laws so that any activity authorized and within the scope of that Act is free from antitrust challenges. The proper issue in this case then is whether there is a plain repugnancy between the scope of the National Health Care Planning and Development Act and the antitrust laws. Another formulation of this same test of somewhat easier application is whether an exemption to the antitrust laws is necessary to make this statutory scheme effective. The Court believes the answer is yes. In the Court's view, voluntary cooperation of the entire health care industry, including third party payors, is essential to the success of the Act.

The National Health Planning and Resource Development Act clearly attempted to set forth health care goals and a regional administrative framework within which achievement of these goals could be sought through cooperation and voluntary compliance with the health care industry. If the Court were to find that private business working in conjunction with the health system agency established by the Act in their area to achieve the goals of the Act were liable or might be liable under the antitrust law for their action, then the Court believes that the accomplishment of the purpose of the goals of the Act would be effectively foreclosed.

Having determined that a conflict exists, the Court must consider the method for resolving the discrepancy. The entire concept of the Act as well as the legislative history convinces the Court that the antitrust laws were not intended to apply to members of the health care industry clearly acting within the scope of the Act. In essence the antitrust laws posit that the public interest will be served best when business enterprises are compelled to compete in markets free of anti-competitive restraints. See *Essential Communities* v. *American Telephone & Telegraph*, 446 F. Supp. 1090 (D.N.J. 1978). The concern of the Senate Committee that considered the health care legislation at issue here was the failure of the health care industry to "respond to classic marketplace forces." See Volume 4, U.S. Code Cong. & Adm. News at p. 7878. In the Committee's view:

> The highly technical nature of medical services together with the growth of third party reimbursement mechanisms act to attentuate the usual forces influencing the behavior of consumers with respect to personal health services. For the most part, the doctor makes purchasing decisions on behalf of the patient and the services are frequently reimbursed under health insurance programs, thus reducing the patient's imme-

diate incentive to contain expenditures. Volume 4, U.S. Code Cong. & Adm. News at p. 7878.

The Committee expressed concern over increasing hospital costs and improper utilization of existing facilities. Volume 4, U.S. Code Cong. & Adm. News at pp. 7893-4. The Committee in fact stated:

> The recent rapid acceleration in the costs of personal health services, far outstripping the rate of inflation in other sectors of the economy, has caused the Committee great concern. Although recognizing the increase in costs experienced by health care providers attributable to general inflation, the Committee wishes to express its concern with respect to the disproportionately high rate of increase in costs of health care services. Volume 4, U.S. Code Cong. & Adm. News at p. 7895.

The Committee attributed many of the cost and duplication problems in the health care industry to reimbursement programs like the ones these defendants sponsor. The legislative history indicates to this Court that any attempts by companies such as these defendants to reduce costs and duplication were to be welcomed and were considered essential to a successful program of cost reduction. In summarizing the Act, the Committee stressed:

> The long-range goal plan is expected to provide for the prevention of unnecessary duplication of resources and assure that quality health services will be available and accessible in a manner which assures continuity of care at reasonable costs for all residents of the area, and which is responsive to the needs and resources of the area. U.S. Code Cong. & Adm. News at p. 7887.

Further, the Committee indicated:

> A health planning agency is directed to seek to implement its long-range goal plan and short-term priorities plan with the assistance of individuals and public and private entities in its health area. In so doing, the agency is directed to provide technical assistance, to the extent practicable, to such entities in bringing about consistency with its health plan. Volume 4, U.S. Code Cong. & Adm. News at p. 7888.

This interpretation of the legislative history is further supported by Representative Paul Rogers in debates over subsequent amendments to this Act. Representative Rogers expressed concern over interpretations of the National Health Planning and Resource Development Act of 1974:

> Concern has been expressed that HSA's and health care providers who voluntarily carry out the mandates of the health planning laws (titles XV and XVI of the Public Health Service Act) may be in violation of the antitrust laws.
>
> The antitrust laws prohibit actions which have the effect of restraining trade or competition. We have found, however, that there is minimal price competition within some parts of the health sector and that often the only competition is around the provision of services. One undesirable result of service competition has been that hospitals and other health care providers have acquired duplicative and expensive equipment and facilities which have led to higher costs for the consumer. In enacting Public Law 93-641, which added titles XV and XVI to the Public Health Service Act, the Congress made a specific judgment that control of the development of health care facilities was needed even though price and service competition might be restrained, and created a health planning system that

could promote the efficient use of health resources through the regulation of and voluntary action by providers.

Title XV requires HSA's to bring together both consumers and providers to plan for an efficient health care system that will meet the area's needs. The HSA governing body is to make decisions in its health systems plan and in appropriateness [sic] review recommendations that affect market allocation. . . . In doing so, the HSA may develop institution-specific recommendations; . . . or develop broader recommendations, such as, three cardiac catheterization laboratories in the area should be consolidated. In either case, it is congressional intent that providers and consumers work together in cooperation with the HSA to determine how best to carry out such recommendations. Without the voluntary cooperation of providers, the provision of title XV dealing with the development of a plan and the review of existing institutional health services could not be carried out.

. . . congressional intent was for the HSA, the provider seeking the certificate of need and other providers which might seek to provide similar services to coordinate their activities to assure that new institutional health services are developed in accordance with the health systems plan for the area.

Although Public Law 93-641 contains no specific exemption from the antitrust laws, an analysis of the activities required of HSA's and providers indicates that Congress sanctioned actions which might otherwise be in violation of our antitrust laws. The intent of Congress was that HSA's and providers, who voluntarily work with them in carrying out the HSA's statutory mandate should not be subject to the antitrust laws. If they were, Public Law 93-641 simply

could not be implemented. Congressional Record—House, No. 18 Part 1, p. H11962-H11963.

A review of the Act and its legislative history compels this Court to concur with Representative Rogers' analysis of congressional intent in enacting the National Health Planning and Resource Development Act. It should be noted that congressional failure to include specific antitrust exemptions for the activities challenged in this case may in part be accounted for by the status of the case law in 1974. The majority of courts confronted with the issue at that time had held that third party reimbursement contracts came within already existing statutory exemptions under the McCarran-Ferguson Act. The fact that this exemption no longer applies in the instant case does not detract from the clear Congressional intent that activities in the health care area to reduce cost and eliminate duplication would not be subject to challenge under the antitrust statutes.

The defendants in support of their claim of implied repeal cite the March 2, 1979 decision of the United States District Court for the Eastern District of Michigan in *Port Huron Valley Hospital, Inc.* v. *City of Pontiac, et al.*, (attached as Exhibit C to the brief of Blue Cross of Kansas City filed April 9, 1979). A review of Judge Kennedy's opinion in *Port Huron* reveals that the existence of circumstances not present in this case were crucial to the reasoning and outcome there. In *Port Huron* the State of Michigan had adopted certificate of need legislation. Although such legislation is contemplated by the provisions of the National Health Care Planning and Research Development Act, *see* 42 U.S.C. 300m 1-5, Judge Kennedy's decision relied on the potential conflict between the state regulation and the federal antitrust laws. The Court does not view *Port Huron* as precedent for its decision in this case. However, it recognizes that the creation of an exemption from the antitrust laws where state certificate of need legislation is passed to insure compliance with the federal act and

application of the antitrust laws in instances of voluntary compliance with the federal act would be anomalous. Although not essential to the decision, the Court in *Port Huron* did find that the legislative history of the National Health Care Planning & Resource Development Act demonstrated congressional intent to at least partially repeal the antitrust laws. In fact Judge Kennedy found that it was the purpose of the Act to check the competition of the free market in the health services area. The Court would concur in this assessment of the Act.

On the basis of the factors outlined above, the Court finds: (1) a clear repugnancy exists between the National Health Care Planning & Resource Development Act and the antitrust laws; (2) Congress intended that action taken pursuant to the Act and clearly within the scope of the Act would be exempt from application of the antitrust laws. Therefore, the defendants' motion for summary judgment Counts I through IV on the grounds that the challenged conduct is exempt from the antitrust laws will be granted.

Two other issues were raised by the defendants which the Court will briefly discuss.

FAILURE TO STATE A CONSPIRACY CLAIM

Defendants characterize the statements concerning the conspiracy as conclusionary and maintain that these allegations are not supported by any allegations of material fact. To maintain a cause of action under § 1 of the Sherman Act a party must set forth the following allegations:

> (1) That the defendants contracted, combined, or conspired among each other; (2) that the combination or conspiracy produced adverse, anti-competitive effects within relevant product and geographic markets; (3) that the objects of and the conduct pursuant to that contract or conspiracy were illegal; and (4) that the plaintiff was injured as a proximate result of that

conspiracy. *Martin B. Glauser Dodge Co.* v. *Chrysler Corp.*, 570 F.2d 72, 81 (3rd Cir. 1977).

The Eighth Circuit has emphasized that the complaint need not set forth specific facts to support its general allegations. *Great Atl. & Pac. Tea Co.* v. *Amalgamated Meat Cutters & Butchers Workmen of North American Local No. 88*, 410 F.2d 650, 652 (8th Cir. 1969). The Court finds that judged by these standards the conspiracy allegations are sufficiently detailed to meet the above requirements and the complaint is not subject to dismissal for failure to allege ultimate facts supporting this theory.

The defendants also argued that sufficient facts are not alleged to demonstrate a boycott within the meaning of § 2(b) of the McCarran-Ferguson Act. Even if the business of insurance regulated by the state is involved so that generally the antitrust laws are inapplicable to a particular activity, an exception to this general rule is created by § 2(b) of the McCarran-Ferguson Act for concerted activity constituting a boycott, coercion or intimidation. Defendants had argued that even if the Court found that the business of insurance regulated by the state was involved, this exception mandated application of the antitrust laws. The issue of whether plaintiff has alleged sufficient facts to demonstrate that the boycott provisions of § 2(b) apply need not be reached since the Court finds that the exemption of the McCarran-Ferguson Act for the business of insurance does not apply.

INTERSTATE COMMERCE REQUIREMENT

Finally the defendants have moved to dismiss the complaint on the grounds that prepaid medical plans offered by not-for-profit corporations are not trade or commerce within the meaning of the Sherman Act. Section 1 of the Sherman Act provides in part:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or com-

merce among the several States, or with foreign nations, is declared to be illegal. . . .

Restraint of trade or commerce is within the prohibition of the commerce requirement only if that restraint affects trade or commerce among the several states or with foreign nations. This effect on commerce requirement is therefore jurisdictional in nature and may be demonstrated in one of two ways. One formulation of the commerce requirement is the "flow of commerce" or qualitative test wherein the restraint complained of is placed directly on goods or services which are themselves in the flow of interstate commerce. Secondly, the requisite commerce requirement may be demonstrated by a quantitative test which involves transactions that although wholly intrastate substantially affect the flow of interstate commerce. See Von Kalinowski, 1 Antitrust Laws and Trade Regulations § 501[1]-[3].

Plaintiffs allegations appear to fall under the latter theory. Paragraph 15 of plaintiff's complaint states that National Gerimedical is one of the first hospitals in the United States specializing in health care services for the elderly. As such, it is intended to serve a national constituency through research and the development of improved health care for the aged. Involvement and effect on interstate commerce is alleged to exist because National Gerimedical is intended to service out of state patients, purchase drugs and supplies from out of state sources, receive income and make disbursements from out of state insurance, and receive out of state financing for construction and operation. Plaintiff's complaint further indicates that Blue Cross's denial of participating status will foreclose to plaintiff a significant portion of the health care market thus affecting the services rendered to out of state patients, the ability to purchase from out of state sources, and the utilization of out of state financing and insurance proceeds. While these allegations are not as specific as might be de-

sired, the Court finds that this issue is controlled by the decision in *Hospital Building Co.* v. *Trustees of Rex Hospital,* 425 U.S. 738, 96 S.Ct. 1848, 48 L.Ed.2d 338 (1976). In Trustees of Rex Hospital plaintiff contended that defendant, a competing hospital, had conspired to restrain plaintiff's planned expansion of facilities in violation of § 1 and § 2 of the Sherman Act. Although the only contended effects on interstate commerce stemmed from plaintiff's provision of intrastate hospital services, the Court concluded that a substantial effect on interstate commerce had been alleged. The Court ruled:

> The complaint, fairly read, alleges that if respondents and their coconspirators were to succeed in blocking petitioner's planned expansion, petitioner's purchases of out-of-state medicines and supplies as well as its revenues from out-of-state insurance companies would be thousands and perhaps hundreds of thousands of dollars less than they would otherwise be. Similarly, the management fees that petitioner pays to its out-of-state parent corporation would be less if the expansion were blocked. Moreover, the multimillion-dollar financing for the expansion, a large portion of which would be from out of State, would simply not take place if the respondents succeeded in their alleged scheme. This combination of factors is certainly sufficient to establish a "substantial effect" on interstate commerce under the Act. *Trustees of Rex Hospital, supra* at 343-4.

In reaching this decision the Court rejected an argument that the conduct is outside the scope of the Sherman Act because the effect on commerce is indirect and the conduct producing the effect not purposefully directed toward interstate commerce. Additionally, the Court found that an effect on commerce may be substantial under the Sherman Act even if its impact on interstate commerce falls far short

of causing enterprises to fold or affecting market prices. In the final analysis, allegations that:

> . . . fairly claim that the alleged conspiracy, to the extent it is successful, will place "unreasonable burdens on the free and uninterrupted flow" of interstate commerce, they are wholly adequate to state a claim. *Trustees of Rex Hospital,* supra at 345.

Defendants argue that prepaid medical plans are not trade or commerce and rely on *United States* v. *Oregon State Medical Society,* 343 U.S. 326, 72 S.Ct. 690, 96 L.Ed. 2d 978 (1951). In the Court's view, *Oregon State Medical Society* is not controlling the instant case. In *Oregon State Medical Society* it was alleged that the state medical association and local medical organizations had agreed not to compete in particular areas in offering their prepaid medical plans. The Court found that the sale of medical services through these prepaid plans was not trade or commerce. The challenged conduct here involves contracts or potential contracts between Blue Cross and the supplier of actual hospital services. Plaintiff's claim that the action complained of will affect the ability of National Gerimedical to provide the desired hospital services is indistinguishable from the effect that plaintiff's action was alleged to have caused in Trustees of Rex Hospital.

For the above reasons, the Court believes the allegations of the complaint establish that failure to obtain status as a "participating hospital" will have an effect on interstate commerce. Therefore, the defendants' motions for summary judgment on the grounds that the requisite effect on trade or commerce has not been alleged will be denied.

PENDENT STATE CLAIMS

Having determined that dismissal of Counts I through IV is appropriate, the Court must decide whether to retain the pendent state claims encompassed in Counts V through VIII. The Court recognizes that it has the power to decide

the state claims. The issue is one of discretion. In *United Mine Workers* v. *Gibbs*, 383 U.S. 715, 86 S.Ct. 1130, 16 L. Ed.2d 218 (1966), the Supreme Court wrote:

> It has consistently been recognized that pendent jurisdiction is a doctrine of discretion, not of plaintiff's right. Its justification lies in considerations of judicial economy, convenience and fairness to litigants; if these are not present a federal court should hesitate to exercise jurisdiction over state claims, even though bound to apply state law to them. . . . Needless decisions of state law should be avoided both as a matter of comity and to promote justice between the parties, by procuring for them a surerfooted reading of applicable law. Certainly, if the federal claims are dismissed before trial, even though not insubstantial in a jurisdictional sense, the state claims should be dismissed as well.

Gibbs seemed to mandate dismissal of state claims where the federal claims were dismissed prior to trial. However, this aspect of *Gibbs* has been relaxed by subsequent Supreme Court cases. *See Rosado* v. *Wyman*, 397 U.S. 397, 90 S.Ct. 1207, 25 L.Ed.2d 442, 450-1 (1970).

Considerations of judicial economy, convenience and fairness to the litigants should be the determinative factors in deciding whether the Court should exercise its pendent jurisdiction or dismiss the State claims. See *Gibbs*, supra; *Rosado*, supra; *Blake* v. *Town of Delaware City*, 441 F. Supp. 1189, 1204-5 (D. Del. 1977). If hearings have been held in a case pending before the Court, discovery conducted and substantial work done towards preparing the action for trial, judicial economy might dictate retaining jurisdiction over the state claims. In this case however, no extensive discovery has been conducted on any issue other than the motion to dismiss and pending a ruling on the motion to dismiss, no answer has even been filed. Further,

the issues researched and briefed by the parties involve federal claims and no issues under the state claims have yet been addressed by the parties or the court; thus, judicial economy does not mandate the retention of the state law claims in this instance. Further, this is not a case where dismissal of the parties will leave the plaintiff without an adequate state forum. Therefore, fairness does not mandate retention in this case. Additionally, the factual situation set forth in plaintiff's complaint may involve unique applications of the state antitrust laws. The Court believes that state courts should be allowed to consider issues involving state antitrust laws which will undoubtedly be raised for the first time by this case. It is a well established principle that needless decisions of state law should be avoided as a matter of comity and to procure for the parties "a surefooted reading of applicable law." See *Gibbs*, supra; and *Euster* v. *Pennsylvania State Horseracing Commission*, 431 F. Supp. 828 (E.D. Pa. 1977).

For the above reasons, the Court believes that a proper exercise of its discretion necessitates dismissal of the pendent state claims.

For all of the reasons outlined above, it is hereby

ORDERED that defendants' motion to dismiss which has been treated as a motion for summary judgment is hereby granted and summary judgment is entered in favor of defendants and against plaintiff on Counts I through IV of plaintiff's complaint; and it is further

ORDERED that in the exercise of its discretion, the pendent state claims set forth in Counts V through VIII are also dismissed without prejudice.

RUSSELL G. CLARK, Judge
United States District Court

Dated: November 2, 1979

UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

No. 79-2018

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER,
Appellant,

v.

BLUE CROSS OF KANSAS CITY, BLUE CROSS ASSOCIATION,
Appellees.

(Filed July 22, 1980)

Before STEPHENSON and MCMILLAN, Circuit Judges, and SACHS, *District Judge.

STEPHENSON, Circuit Judge.

The National Gerimedical Hospital, plaintiff-appellant, appeals from a summary judgment granted to defendant-appellee Blue Cross of Kansas City. National had charged Blue Cross and others [1] with violations of sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2. The trial court [2] found Blue Cross' activities to be taken pursuant to Public Law 93-641, the National Health Care Planning and Resources Development Act of 1974, 42 U.S.C. § 300k, *et seq.;* that there was a repugnancy between the Act and the antitrust laws; and that consequently, under the doctrine of implied immunity, Blue Cross' activities were immune from

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* The Honorable Howard F. Sachs, United States District Judge for the Western District of Missouri, sitting by designation.

[1] Blue Cross of Kansas City and Blue Cross Association were named defendant coconspirators. There were several non-defendant coconspirators listed in the plaintiff's complaint, including Mid-America Health Systems Agency, Inc. (MAHSA).

[2] The Honorable Russell G. Clark, United States District Judge for the Western District of Missouri.

the antitrust laws. *National Gerimedical Hospital & Gerontology Center* v. *Blue Cross*, 479 F. Supp. 1012 (W.D. Mo. 1979). We affirm the district court.

I. Statutory Background

The related health care statutes, as they existed during the relevant time period, are as follows.

Prior to the National Health Care Planning and Resources Development Act of 1974, the Public Health Service Act, 42 U.S.C. § 291, *et seq.* (known as the Hill-Burton Act) was the primary legislation channeling federal funds to states in support of construction and modernization of health care facilities. The Hill-Burton Act provides, as does much federal legislation involving state cooperation, for voluntary participation by the states. The participating state submits a state plan to HEW, which designates a particular state agency to be in charge of administering the state program and determining, *inter alia*, the need for new or expanded health care facilities. While an applicant could build without approval by the state agency, such applicant would not be eligible for reimbursement by the federal government. *Lakeside Mercy Hospital, Inc.* v. *Indiana State Board of Health*, 421 F. Supp. 193, 196-97 (N.D. Ind. 1976).

Other prior legislation providing for channeling federal funds into health care programs includes the Public Health Service Act § 314, 42 U.S.C. § 246 (amended 1978 and 1979). Under this program, federal funds are channeled to participating states that submit, and have approved by HEW, a Comprehensive Health Planning State Plan. This legislation provides for a state agency to be designated to screen health care applications in order to verify the need for new facilities and programs under the approved state plan, and also, in cooperation with the state agency, the Act provides for Area Comprehensive Health Planning Agencies, *Id.* at 197.

Section 1122 of the Social Security Act, 42 U.S.C. § 1320a-1 (amended 1978 and 1979), enacted in 1972, provides for a participating state program for repayment provisions for Medicaid and Medicare, for which repayment prior to that time had not been dependent upon need approval by any of the various state health agencies (those designated by the state pursuant to compliance with federal requirements in order to be a participating state). Section 1122 of the Social Security Act authorizes HEW to enter into agreements with participating states whereby a state agency is designated as a health planning agency. This agency develops a state plan and makes recommendations as to the need of proposed expenditures for health care facilities, in conformity with regulations promulgated by HEW. Once final approval by HEW is received, the capital expenditure qualifies for purposes of reimbursement, via Medicaid and Medicare payments, the portion of fees allocable to return of depreciation, debt service and other capital related expenditures. *Id.*

The purpose of the National Health Care Planning and Resources Development Act of 1974, also providing for a participating state program, is "to facilitate the development of recommendations for a national health planning policy, to augment areawide and State planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy." 42 U.S.C. § 300k(b).

Part B of the Act, 42 U.S.C. § 3001, provides for the establishment of health service areas and corresponding health systems agencies (HSAs). The purposes of the HSAs as stated in the Act include, *inter alia*, "preventing unnecessary duplication of health resources." 42 U.S.C. § 300*l*-2(a). In order to accomplish its purposes, the HSA is to establish a health systems plan (HSP) and an annual implementation plan (AIP) which will achieve the goals of

the HSP. 42 U.S.C. § 300*l*-2(b)(2). The Act specifically provides that the HSA shall implement the HSP and AIP, and "*shall* seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area." 42 U.S.C. § 300*l*-2(c)(1) (emphasis added). It is this section of the Act upon which the district court primarily rests its finding of antitrust immunity for the actions of Blue Cross.

II. Facts

Construction of the National Gerimedical Hospital began in August 1976 and was completed in September 1978. On October 4, 1977, Hospital submitted to Blue Cross a request for a member hospital contract. Pursuant to such contracts Blue Cross reimburses individual members the cost of all covered health services received at member hospitals. If health services are received by individual members at nonmember hospitals, Blue Cross individual members receive only up to eighty percent of the cost of the covered medical services. Also, for health services received at member hospitals, Blue Cross reimburses or pays the hospital for the services provided its individual members; with a nonmember hospital, the reimbursement is paid to the individual member, not to the hospital.

Blue Cross advised Hospital that Hospital must first secure need approval of Mid-America Health Services Agency (MAHSA) in order to be eligible for favorable consideration by Blue Cross for a member hospital contract.

MAHSA, named as a non-defendent alleged coconspirator,[3] is a private not-for-profit Missouri corporation engaged in voluntary health planning. MAHSA was conditionally designated an HSA under the Act and was notified of its designation for the eight county bi-state region of the metropolitan Kansas City area by letter from HEW

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[3] *See* note 1 *supra*.

on April 7, 1976. *Mid-America Regional Council* v. *Mathews,* 416 F. Supp. 896, 899 (W.D. Mo. 1976). Thus during the relevant time period of this case, MAHSA enjoyed this status.

Prior to this time period, Missouri had participated in the Social Security Act § 1122 Capital Health Care Expenditures Program, which included a State Planning Agency that performed section 1122 program reviews, as discussed *infra.* 42 U.S.C. § 1320a-1 (amended 1978 and 1979). Blue Cross had required that large capital expenditures be approved by the local and regional planning arm of the section 1122 State Planning Agency before, *i.e.,* a hospital could be a member institute. This Capital Expenditure Program, as discussed *infra,* was designed to assure that federal funds appropriated for Medicaid and Medicare were not used to support unnecessary capital expenditures for health care facilities.

Area agencies established under 42 U.S.C. § 246 (amended 1978 and 1979), discussed *infra,* Area Comprehensive Health Planning Agencies (CHPs), were used in conjunction with the need approvals necessary under 42 U.S.C. § 1320a-1 (amended 1978 and 1979). The applicant for Medicaid and Medicare cost reimbursement had to seek a favorable recommendation from the CHP and secure a favorable determination of need from the state planning agency, the Missouri State Health Planning and Development Agency. The CHP for Missouri was MAHSA. The National Health Planning and Resources Development Act of 1974 gives preference to § 246 area agencies, CHPs and existing regional planning areas. 42 U.S.C. § 300*l*-4(b)(4) and § 300*l*(a)4.

On June 30, 1976, Missouri, a participating state under 42 U.S.C. § 1320a-1 (amended 1978 and 1979) since 1973, refused to renew Missouri's contract with HEW and Missouri's Program for Capital Health Care Expenditures was terminated.

On July 21, 1976, as reflected by a "Special Newsletter" to Blue Cross member hospitals in Missouri, Blue Cross gave notice that all projects in the Kansas City metropolitan area not reviewed and approved by MAHSA would not be reimbursible by Blue Cross of Kansas City.

> Blue Cross of Kansas City has been observing with considerable interest the events regarding the State of Missouri's cancellation of the SSA-1122 Capital Expenditure Program. It appears at this time that the final position of the Department of Health, Education, and Welfare on this matter has not been clarified with respect to reimbursement sanctions.[4] It also appears that the State of Missouri has no intention of reinstating the State Comprehensive Health Planning Agency to perform the SSA-1122 program review.
>
> In view of this action, the Provider Relations Committee of the Blue Cross Board of Trustees felt it necessary to advise all Missouri Member Hospitals of our position on this matter. As you are aware, the Member Hospital Contract contains a provision that capital expenditures of over $350,000 or 5% of the hospital's operating expense in the most recent fiscal year, whichever is lesser, be approved by the local or regional planning agency. Since the State Planning Agency no longer exists, Blue Cross of Kansas City will look to the local Health Systems Agency for approval of such capital projects. That Health Systems Agency in the Kansas City metropolitan area is the Mid-America Health Systems Agency and in the balance of our operating area, Area II Health Systems Agency. *All projects not reviewed and approved by these Health Systems Agencies will not be reimbursible by Blue Cross of Kansas City.*

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[4] Appellant advises us that no question has been raised concerning Hospital's entitlement to full Medicare reimbursement.

> Therefore, we urge you to continue working with these agencies and Blue Cross of Kansas City in future planning needs for your hospital. Should you have any questions regarding our position on this matter, please do not hesitate to consult with us.

MAHSA was, of course, designated as the HSA under the Act. However, Missouri, during the relevant time period, had no law implementing the Act in Missouri nor designating any state agency thereunder in accordance with 42 U.S.C. § 300m.

MAHSA had publicly stated that it would disapprove and not consider favorably the addition of any acute care hospital beds; acute care hospital beds are the type Hospital provided; Hospital did not submit an application for need review to MAHSA; Hospital's application for a member contract with Blue Cross was denied in March 1978 by Blue Cross because Hospital had not received approval through the voluntary health planning process as required by the Special Newsletter. Hospital then filed this lawsuit.

III. Analysis

National argues that by requiring National to get need approval from MAHSA before it applies for a member hospital contract with Blue Cross, Blue Cross violates the antitrust laws. National contends that the requirement constitutes a contract, combination or conspiracy in restraint of trade, Sherman Act § 1, 15 U.S.C. § 1, and an abuse of Blue Cross' monopoly power in the private health care reimbursement plan market, Sherman Act § 2, 15 U.S.C. § 2.

What defeats National's otherwise appealing argument are the specific provisions of the National Health Planning and Resources Development Act for voluntary cooperation and assistance of private entities and persons in the community and health care market. While the doctrine of im-

plied immunity is to be used sparingly and only when necessary, *Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659 (1975), these provisions make the instant situation one well-suited for its use.

The necessity of application of the doctrine of implied immunity arises if there is (1) a clear repugnancy between the antitrust laws and the specific conduct at issue and (2) if the intent of Congress is that implied repeal of the antitrust laws was intended. *Essential Communication Systems, Inc.* v. *AT&T*, 446 F. Supp. 1090, 1094-95 (D.N.J. 1978).

As to the first prerequisite, the district court herein stated its finding of repugnancy best when it stated:

> If the Court were to find that private business working in conjunction with the health systems agency established by the Act in their area to achieve the goals of the Act were liable or might be liable under the antitrust laws for their action, then * * * the accomplishment of the purpose of the goals of the Act would be effectively foreclosed.

National Gerimedical Hospital & Gerontology Center v. *Blue Cross, supra*, 479 F. Supp. 1012, 1021 (W.D. Mo. 1979).

National's emphasis upon the fact that Missouri was not a participating state—"at all times here pertinent, Missouri had no law implementing P.L. 93-641 in Missouri nor designating any state agency thereunder in accordance with 42 U.S.C. § 300m" (brief for appellant at 12-13)—misses the focus of the doctrine of implied immunity. The doctrine should not be confused with the state action exemption to the antitrust laws as articulated in *Parker* v. *Brown*, 317 U.S. 341 (1943). The doctrine of implied immunity, in fact,

> is actually a subspecie of implied statutory repeal. *See, Gordon* v. *N.Y. Stock Exchange*, 422 U.S. 659, 682, 95 S.Ct. 2598, 45 L.Ed.2d 463 (1975), and *U. S.* v. *Southern*

Motor Carriers Rate Conference, 439 F. Supp. 29, 35 (N.D. Georgia, 1977). It is one of several distinct judicially created rules, which include "primary jurisdiction" and "exhaustion of administrative remedies", designed to resolve potential conflicts between two regimes with federal statutory authorization to regulate the conduct of business entities: federal administrative agencies and federal courts enforcing (among others) the antitrust laws.

The antitrust laws posit that the public interest is best served when business enterprises are compelled to compete in markets free of anti-competitive restraints. In contrast, the basic premise of administrative regulation is that the freedom of business entities must be in some degree curtailed to maximize the general welfare. When the same conduct falls within the scope of both the antitrust laws and a regulatory scheme, potential conflicts of competency and policy are resolved under the doctrine of implied immunity.

Essential Communication Systems, Inc. v. *AT&T, supra,* 446 F. Supp. at 1094 (footnote omitted). Missouri's lack of state participation did not affect the Act which set up a regulatory scheme which designated MAHSA as a regulatory need review agency. More specifically, it has no effect upon that portion of the legislation which calls for a regulatory system which included the designated HSA implementing the HSP and AIP "with the assistance of individuals and public and private entities in its health service area." 42 U.S.C. § 300*l*-2(c)(1).

The extent of this regulatory scheme is demonstrated by the district court's discussion.

Mid-America Health Systems Agency was one of 205 regional health systems agencies established under the Act * * *. In November of 1977 Mid-America Health Systems established a health systems plan for 1978

through 1982 in this region. Increasing hospital costs and unnecessary duplication of facilities and equipment were considered two of the biggest problems in this region. The health systems plan adopted by Mid-America Health Systems recognized:

> Problem—The acute inpatient care system does not function in a coordinated manner which is cost-effective in the delivery of acute care services at the most appropriate level consistent with quality standards. (Health Systems Plan at pp. 6-19.)

The goal in this area was recognized as:

> Goal: Improve the health of the population in the MAHSA area through an adequately available and accessible acute inpatient care system coordinated in a manner that fosters containment of health care costs and provides quality of care in a culturally acceptable manner. (Health Systems Plan at pp. 6-19.)

To implement this goal MAHSA established a number of objectives in this area and specified particular methods that could be utilized to achieve each objective. Objective No. 4 seeks to:

> **Objective #4**
>
> Maintain a rate of increase in total expenditures for hospital care services which does not exceed the rate of increase in the medical care services component of the Consumer Price Index. (Health Systems Plan at pp. 6-21.)

As one of the nine methods set forth to meet this goal, Mid-America Health System suggested:

> (6) Third party payors and the hospital community should work together to develop uniform reporting systems and procedures such that meaningful hospital-

to-hospital and year-to-year hospital cost and service-by-service utilization comparisons can be made. (Health Systems Plan at pp. 6-22.)

National Gerimedical Hospital & Gerontology Center v. *Blue Cross, supra,* 479 F. Supp. at 1020-21. Implied immunity can be found in "particular and discrete instances to assure that the federal agency entrusted with regulation in the public interest could carry out that responsibility free from the disruption of conflicting judgments that might be voiced by courts exercising jurisdiction under the antitrust laws." *United States* v. *National Association of Securities Dealers, Inc.,* 422 U.S. 694, 734 (1975).

We agree with the district court's finding of clear repugnancy between the Act and the antitrust laws, as the Act and regulatory scheme clearly call for the action which has now become the basis of an antitrust claim.

We now examine the history of the Act in order to determine the congressional intent in regard to immunity. The district court concluded, after a thorough review of the legislative history, that it was the intent of Congress to immunize this type of voluntary action from the antitrust laws. We cannot improve on the district court's discussion:

> In essence the antitrust laws posit that the public interest will be served best when business enterprises are compelled to compete in markets free of anti-competitive restraints. * * * The concern of the Senate Committee that considered the health care legislation at issue here was the failure of the health care industry to "respond to classic marketplace forces." See Volume 4, U.S. Code Cong. & Admin. News at p. 7878, U.S. Code Cong. & Admin. News 1974, p. 7878. In the Committee's view:
>
> > The highly technical nature of medical services together with the growth of third party reimburse-

> ment mechanisms act to attentuate the usual forces influencing the behavior of consumers with respect to personal health services. For the most part, the doctor makes purchasing decisions on behalf of the patient and the services are frequently reimbursed under health insurance programs, thus reducing the patient's immediate incentive to contain expenditures. Volume 4, U.S. Code Cong. & Admin. News at p. 7878.

The Committee expressed concern over increasing hospital costs and improper utilization of existing facilities. Volume 4, U.S. Code Cong. & Admin. News at pp. 7893-4. The Committee in fact stated:

> The recent rapid acceleration in the costs of personal health services, far outstripping the rate of inflation in other sectors of the economy, has caused the Committee great concern. Although recognizing the increase in costs experienced by health care providers attributable to general inflation, the Committee wishes to express its concern with respect to the disproportionately high rate of increase in costs of health care services. Volume 4, U.S. Code Cong. & Admin. News at p. 7895.

The Committee attributed many of the cost and duplication problems in the health care industry to reimbursement programs like the ones these defendants sponsor. The legislative history indicates to this Court that any attempts by companies such as these defendants to reduce costs and duplication were to be welcomed and were considered essential to a successful program of cost reduction. In summarizing the Act, the Committee stressed:

> The long-range goal plan is expected to provide for the prevention of unnecessary duplication of

resources and assure that quality health services will be available and accessible in a manner which assures continuity of care at reasonable costs for all residents of the area, and which is responsive to the needs and resources of the area. U.S. Code Cong. & Admin. News at p. 7887.

Further, the Committee indicated:

A health planning agency is directed to seek to implement its long-range goal plan and short-term priorities plan with the assistance of individuals and public and private entities in its health area. In so doing, the agency is directed to provide technical assistance, to the extent practicable, to such entities in bringing about consistency with its health plan. Volume 4, U.S. Code Cong. & Admin. News at p. 7888.

This interpretation of the legislative history is further supported by Representative Paul Rogers in debates over subsequent amendments to this Act. Representative Rogers expressed concern over interpretations of the National Health Planning and Resource Development Act of 1974:

Concern has been expressed that HSA's and health care providers who voluntarily carry out the mandates of the health planning laws (titles XV and XVI of the Public Health Service Act) may be in violation of the antitrust laws.

The antitrust laws prohibit actions which have the effect of restraining trade or competition. We have found, however, that there is minimal price competition within some parts of the health sector and that often the only competition is around the provision of services. One undesirable result of service competition has been that hospitals and

other health care providers have acquired duplicative and expensive equipment and facilities which have led to higher costs for the consumer. In enacting Public Law 93-641, which added Titles XV and XVI to the Public Health Service Act, the Congress made a specific judgment that control of the development of health care facilities was needed even though price and service competition might be restrained, and created a health planning system that could promote the efficient use of health resources through the regulation of and voluntary action by providers.

Title XV requires HSA's to bring together both consumers and providers to plan for an efficient health care system that will meet the area's needs. The HSA governing body is to make decisions in its health systems plan and in appropriateness [sic] review recommendations that affect market allocation . . . In doing so, the HSA may develop institution-specific recommendations; . . . or develop broader recommendations, such as, three cardiac catheterization laboratories in the area should be consolidated. In either case, it is congressional intent that providers and consumers work together in cooperation with the HSA to determine how best to carry out such recommendations. Without the voluntary cooperation of providers, the provision of title XV dealing with the development of a plan and the review of existing institutional health services could not be carried out.

. . . congressional intent was for the HSA, the provider seeking the certificate of need and other providers which might seek to provide similar services to coordinate their activities to assure that new institutional health services are developed in accordance with the health systems plan for the area.

> Although Public Law 93-641 contains no specific exemption from the antitrust laws, an analysis of the activities required of HSA's and providers indicates that Congress sanctioned actions which might otherwise be in violation of our antitrust laws. The intent of Congress was that HSA's and providers who voluntarily work with them in carrying out the HSA's statutory mandate should not be subject to the antitrust laws. If they were, Public Law 93-641 simply could not be implemented. Congressional Record—House, No. 18 Part 1, p. H11962-H11963.

National Gerimedical Hospital & Gerontology Center v. *Blue Cross, supra,* 479 F. Supp. at 1021-23.

We adopt the district court's discussion, as set out above. We affirm the district court's holding; the doctrine of implied immunity applies to Blue Cross' voluntary cooperation with the congressionally designated HSA in requiring Hospital to obtain need approval from MAHSA prior to applying for a Blue Cross membership contract.

Appellee Blue Cross also argues that the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15, exempts the challenged conduct from the federal antitrust laws. We agree, in all respects, with the district court's holding that *Group Life & Health Insurance Co.* v. *Royal Drug Co., Inc.,* 440 U.S. 205 (1979) (defining "the business of insurance" in connection with the McCarran-Ferguson Act) controls. *National Gerimedical Hospital & Gerontology Center* v. *Blue Cross, supra,* 479 F. Supp. at 1016-19. Thus, we hold that the McCarran-Ferguson Act insurance exemption is not applicable in this case.

The district court is affirmed.

A true copy.

Attest:

CLERK, U.S. COURT OF APPEALS, EIGHTH CIRCUIT.

JUDGMENT

UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

No. 79-2018

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER
Appellant,

v.

BLUE CROSS OF KANSAS CITY, BLUE CROSS ASSOCIATION,
Appellees.

APPEAL FROM the United States District Court for the Western District of Missouri.

THIS CAUSE came on to be heard on the original designated record of the United States District Court for the Western District of Missouri and briefs of the respective parties and was argued by counsel.

ON CONSIDERATION WHEREOF, it is now here ordered and adjudged by this Court, that the judgment of the said District Court, in this cause, be, and the same is hereby, affirmed in accordance with the opinion of this Court.

July 22, 1980

Costs taxed in favor of Appellee, Blue Cross Assn:

Costs of printing 10 copies of brief	$726.34
Total costs of Appellee, Blue Cross Assn., for recovery from Appellant in the U.S. District Court	$726.34

A true copy

ATTEST: ROBERT D. ST. VRAIN
Clerk, U.S. Court of Appeals, 8th Circuit

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UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 79-2018

NATIONAL GERIMEDICAL HOSPITAL
AND GERONTOLOGY CENTER,
Appellant,

vs.

BLUE CROSS OF KANSAS CITY, et al.,
Appellee.

ORDER

The Court, having considered appellant's petition for rehearing and suggestions for rehearing *en banc* and being now fully advised in the premises, hereby orders the petition for rehearing and suggestions for rehearing *en banc* denied.

August 22, 1980

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No. 80-802

IN THE

Supreme Court of the United States

October Term, 1980

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER,

Petitioner,

v.

BLUE CROSS OF KANSAS CITY AND BLUE CROSS ASSOCIATION,

Respondents.

On Petition For A Writ of Certiorari To The United States Court of Appeals For The Eighth Circuit

BRIEF OF RESPONDENT BLUE CROSS ASSOCIATION IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

The National Health Planning and Resources Development Act of 1974 directs federally-designated regional Health Systems Agencies, with the assistance of private parties, to restrain unneeded construction of hospital facilities.

In this case, a hospital which was constructed in disregard of a determination by a Health Systems Agency that additional hospital beds were unwarranted in its area, applied to the local Blue Cross Plan for a reimbursement contract. The Blue Cross Plan adhered to its policy of contracting only with hospitals for which there was a community health need.

The question presented is whether the Health Planning Act of 1974 partially repeals the antitrust laws by implication in the specific situation where a Blue Cross Plan follows a determination made by a Health Systems Agency against new hospital construction.

TABLE OF CONTENTS

	Page
Statutory Provisions Involved	1
Statement of the Case	2
Reasons for Denying the Writ	6
I. The Decision of the Court of Appeals Does Not Create a Precedent Which Warrants Review by This Court	6
II. The Health Planning Act of 1974 Is Irreconcilable With—"Repugnant" to—the Antitrust Laws in the Circumstances of this Case	9
III. Petitioner's Arguments Are Without Merit	13
A. The Health Planning Act of 1974 Is Premised Upon the Elimination of Competition for Inpatient Services	13
B. The 1979 Amendments to the Health Planning Act of 1974 Preclude Competition For Inpatient Services	14
C. The Court Below Did Not Grant A "Blanket Exemption"	16
D. Petitioner's Additional Arguments Are Invalid.	18
IV. Petitioner Is Seeking to Undermine Congress' Purpose to Control Hospital Costs	20
Conclusion	21
Appendix	1a

TABLE OF AUTHORITIES

Cases

Cavanagh Communities Corp. v. New York Stock Exchange, 422 F. Supp. 382 (S.D. N.Y. 1976) 9

Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975)..... 8

Gordon v. New York Stock Exchange, Inc., 422 U.S. 659 (1975) 17

Hospital Building Co. v. Trustees of Rex Hospital, 425 U.S. 738 (1976)..... 9

Huron Valley Hospital, Inc. v. City of Pontiac, 466 F. Supp. 1301 (E.D. Mich 1979), *appeal docketed*, No. 79-1265 (6th Cir. May 16, 1979)..... 7-8

Latin America/Pacific Coast S.S. Conf. v. FMC, 465 F. 2d 542 (D.C. Cir. 1972)..... 13

National Soc'y of Professional Engineers v. United States, 435 U.S. 679 (1978)..... 8

North Carolina v. P.I.A. Asheville, Inc., Civ. No. A-C-80-29 (W.D.N.C. filed Feb. 22, 1980)..... 7

Northern Pacific Railway Co. v. United States, 356 U.S. 1 (1958)..... 13

Pan American World Airways, Inc. v. United States, 371 U.S. 296 (1963)..... 18

Parker v. Brown, 317 U.S. 341 (1943) 8, 19

United States v. National Association of Securities Dealers, 422 U.S. 694 (1975) 17, 18

Statutes

McCarran-Ferguson Act

15 U.S.C. § 1012 9

Mo. Ann. Stat. § 197.300 *et seq.* (Vernon Supp. 1980)... 6

Mo. Rev. Stat. § 354.010 *et seq.* 5

National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300k *et seq.* ..... passim

Sherman Act, Sections 1, 2
15 U.S.C. §§ 1, 2 ..... 1, 16

Miscellaneous

CHAYET & SONNENREICH, P.C., CERTIFICATE OF NEED: AN EXPANDING REGULATORY CONCEPT (1978) 6

Hearings on S.570 Before the Sub of the Senate Comm. on Labor and Human Resources, 96th Cong., 1st Sess. 110 (1979) 13-14

Miller, *Antitrust and Certificate of Need: Health Systems Agencies, The Plan Act, and Regulatory Capture,* 68 Georgetown L.J. 873 (1980) 16

National Guidelines for Health Planning § 121.201, 43 Fed. Reg. 13045 (1978) 3

S. Rep. No. 93-1285, 93d Cong. 2d Sess., *reprinted in* [1974] U.S. Code Cong., & Ad. News 7842 ..... 3-4, 10-11, 13, 18, 20

S. Rep. No. 96-96, 96th Cong. 1st Sess., *reprinted in* [1979] U.S. Code Cong. & Ad. News, 1306 ..... 3, 20

No. 80-802

IN THE

Supreme Court of the United States

October Term, 1980

NATIONAL GERIMEDICAL HOSPITAL
AND GERONTOLOGY CENTER,
Petitioner,

v.

BLUE CROSS OF KANSAS CITY AND
BLUE CROSS ASSOCIATION,
Respondents.

BRIEF OF RESPONDENT BLUE CROSS ASSOCIATION IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI

This brief is submitted on behalf of respondent Blue Cross Association in opposition to the petition for a writ of certiorari. The Blue Cross Association concurs in petitioner's statements under the headings *Opinions Below* and *Jurisdiction.*

STATUTORY PROVISIONS INVOLVED

The statutes involved in this case are set forth in the Appendix at the end of this brief. These include Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2, and certain provisions of the National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300k *et seq.* The 1974 Act, which is involved in this case, was extensively amended in 1979. Pub. L. No. 96-79, 93 Stat. 593.

STATEMENT OF THE CASE

"Overbedding" is the term used to describe the construction of excess hospital facilities in a region, creating needless inflation in the cost of health care. While the cost of all health care has risen at an alarming rate in recent years, one of the most serious problems involves "inpatient" services, *i.e.*, hospital stays. To combat this, Congress enacted the National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300k *et seq.* (the "Health Planning Act of 1974") to develop "a national health planning policy" and to facilitate regional and state planning. 42 U.S.C. §§ 300k(a)(4); 300k(b).

The key elements under this legislation are the regional Health Systems Agencies ("HSA's"), which are charged with comprehensive regional health planning. Each HSA includes a professional staff and a governing body, the majority of which must be composed of consumers of health care and the remainder of "providers," which are defined to include third-party payers such as Blue Cross Plans. 42 U.S.C. § 300*l*-1 (b)(3)(C)(ii).

The duties of the HSA under the Act include "restraining increases in the cost of providing . . . health services" and "preventing unnecessary duplication of health resources." 42 U.S.C. § 300*l*-2(a)(3),(4). Each HSA has "as its primary responsibility the provision of effective health planning for its health service area." 42 U.S.C. § 300*l*-2(a)(5). This includes the reduction of documented inefficiencies and the formation of long-term Health Systems Plans ("HSP's"), which must be implemented *"with the assistance of individuals and public and private entities."* 42 U.S.C. § 300*l*-2(c)(1) (emphasis added).

In 1976 the United States Department of Health, Education and Welfare (now Health and Human Services) designated Mid-America Health System, Inc. ("MAHSA") as the HSA for the eight-county bi-state region comprising the metropolitan Kansas City area. (App. 4a).[1] MAHSA is a not-

[1] As noted by the Court of Appeals (App. 4a), MAHSA was notified of its conditional designation by HEW by letter of April 7,

for-profit "quasi-public" corporation,[2] whose sole purpose is to provide health care planning for the Kansas City area. Pursuant to its statutory responsibilities, MAHSA developed a long-range Health Systems Plan, "HSP 1978-1982," which was formally adopted as the five-year Health Systems Plan for the region in 1977. (HSP Foreword).

In the Plan, MAHSA identified, as one of its main objectives, the need to find a solution to the growing surplus of hospital beds in the Kansas City area. (HSP at 6-19 and 8-1). It found that the acute inpatient care system was already meeting the needs of the population (*id.* at 7-3) and that by 1983 the region would have as many as 2,420 surplus hospital beds. (*Id.* at 5-68 and 7-3). The area already had five staffed hospital beds for each 1,000 population (*id.* at Appendix F, Table 9), and if all beds then planned or under construction had been built, the figure would have risen to 6.3 beds per 1,000. (*Id.* at Appendix F, Table 9). HEW guidelines recommend fewer than four beds per 1,000. National Guidelines for Health Planning, § 121.201, 43 Fed. Reg. 13045 (1978). Unused hospital beds cost a community one-third of their initial cost incrementally each year, S. Rep. No. 93-1285, 93d Cong., 2d Sess., *reprinted in* [1974] U.S. Code Cong. & Ad. News

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1976. All designations of HSA's were conditional at that time because the program was still relatively new. *See* 42 U.S.C. § 300*l*-4(b); S. Rep. No. 96-96, 96th Cong., 1st Sess. 6, *reprinted in* [1979] U.S. Code Cong. & Ad. News 1306, 1311.

As used herein, "App." refers to the appendices to the petition for certiorari; "Pet." refers to the petition itself; and "BCA Aff." indicates the affidavit which was filed with the district court as Exhibit A to the BCA Suggestions of August 14, 1978.

[2] In the Court of Appeals, the Federation of American Hospitals, as *amicus curiae,* characterized MAHSA as a "quasi-public agency." (Federation of American Hospitals' Brief at 13). The Federation of American Hospitals is an organization representing investor-owned, profitmaking private hospitals (Federation of American Hospitals' Motion for Leave to File Amicus Curiae Brief at 2), which was represented in the Court of Appeals by the lead counsel now representing National Gerimedical before this Court.

7879, and there is a marked tendency for surplus beds to be filled unnecessarily by patients who either do not genuinely need to be hospitalized or who stay longer than is medically warranted. *Id.* at 7878. On the basis of its findings, MAHSA determined that it was unnecessary to add to the number of acute care hospital beds available in the Kansas City area and announced that no additional beds would be approved. (App. 7a).

Disregarding this determination, petitioner National Gerimedical Hospital and Gerontology Center ("National Gerimedical") proceeded to erect a new 120-bed acute care hospital in metropolitan Kansas City. A year before its opening on October 16, 1978, National Gerimedical applied to the local Blue Cross Plan, Blue Cross of Kansas City ("Blue Cross"), for a participating contract which would have enabled National Gerimedical to receive reimbursement directly from Blue Cross. (Pet. at 3). Blue Cross replied that it would adhere to its pre-existing policy of contracting with newly built or expanded hospitals only when their area HSA had determined that the community needed the additional facilities. (App. 5a-7a). On March 21, 1978, Blue Cross informed National Gerimedical that its application had been denied. National Gerimedical proceeded to open seven months later. (Pet. at 3).

The complaint, filed in the United States District Court for the Western District of Missouri, charged Blue Cross and the Blue Cross Association ("BCA") with conspiring with MAHSA and others[3] to refuse to deal with National Gerimedical and thereby to place it at a competitive disadvantage in violation of Sections 1 and 2 of the Sherman Act. The district judge granted summary judgment, dismissing the complaint on the ground that the Health Planning Act of 1974 impliedly repealed the federal antitrust laws. The United States Court of Appeals for the Eighth Circuit affirmed by opinion without dissent. A

[3] MAHSA and the others were identified as non-party co-conspirators. (Complaint ¶¶ 6-12).

rehearing was denied, also without dissent. National Gerimedical then petitioned this Court for a writ of certiorari.

BCA is an Illinois not-for-profit membership corporation to which Blue Cross Plans throughout the United States belong. (BCA Aff., ¶ 2). BCA's functions include statistical and research services for the local Plans. (*Id.* ¶ 3). BCA does not do business in Missouri and does not offer health care plans in Missouri or elsewhere; it does not contract with hospitals. (*Id.* ¶¶ 3, 4, 7). The statement of purpose in BCA's Articles of Incorporation specifies that "inherent in [BCA's] purposes is a recognition that State and local Plans are, and should be, autonomous in their operation and that the needs, facilities, resources and practices of the respective areas shall be given due consideration." (BCA Aff., ¶ 3). Nevertheless, National Gerimedical alleged in its complaint that BCA conspired in formulating the local Blue Cross policy of refusing to contract with unapproved hospitals. (Complaint ¶ 18(a)).

Blue Cross of Kansas City ("Blue Cross") is a not-for-profit community service organization, organized pursuant to Missouri law[4] and subject to the supervision and regulation of the Missouri Director of Insurance. It offers individual and group health care reimbursement plans to the general public in Missouri and Kansas. (Complaint ¶ 4). Blue Cross subscribers account for "approximately one fourth of all area hospital admissions" in the Kansas City region. (Pet. at 4). A majority of Blue Cross' board and its executive committee are representatives of the public, consisting of community, business and labor leaders. (Blue Cross Int. Ans., Exhibit A). Blue Cross is a member of BCA, but BCA has neither the power nor the duty to control Blue Cross' contracts with any hospital. (BCA Aff., ¶ 4; BCA Int. Ans., Exhibits E & F).

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[4] Mo. Rev. Stat. § 354.010 *et seq.*

REASONS FOR DENYING THE WRIT

I. The Decision of the Court of Appeals Does Not Create a Precedent Which Warrants Review by This Court

Although petitioner contends that the decision of the Court of Appeals is of substantial precedential significance and "likely to stimulate many other cases in this area" (Pet. at 10), this case cannot arise again. As the Court of Appeals pointed out (App. 5a), National Gerimedical took advantage of a hiatus in Missouri health planning review of proposed hospital capital expenditures which arose in June 1976, when Missouri refused to renew its contract with HEW under section 1122 of the Social Security Act, 42 U.S.C. § 1320a-1. In August, 1979 (effective October 1, 1980) Missouri enacted certificate of need legislation that bars the construction of new hospitals[5] which have not been approved by a state planning agency, acting under the guidance of an HSA.[6] Mo. Ann. Stat. §§ 197.300 *et seq.* (Vernon Supp. 1980).

On a national scale, every other state has a certificate of need law which precludes construction of unapproved hospitals except Louisiana, where such legislation has been proposed and need review is presently conducted under section 1122 of the Social Security Act.[7] Accordingly, the opportunity to build an

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[5] The application of the decision below is further limited by the fact that every other acute care hospital in the Kansas City area already has a participating contract. (Pet. at 4).

[6] As described by the Court of Appeals (App. 2a-3a), federal legislation requires states to establish need approval requirements for new construction in order to be eligible for federal funding and Medicaid or Medicare repayment programs. 42 U.S.C. §§ 246, 291, 1320a-1. *See also* 42 U.S.C. § 300m-2(a)(4). The Department of Health and Human Services (formerly HEW) is authorized to enter into agreements with participating states, designating a state agency as the health planning authority charged with need review. 42 U.S.C. 1320a-1. The state agency must act in coordination with the recommendations of the regional HSA's, 42 U.S.C. §§ 300*l*-2(f), 300m-2(a)(4)(B), and the certificate of need program must provide for procedures and penalties to enforce its requirements. *Id.*

[7] *See* CHAYET & SONNENREICH, P.C., CERTIFICATE OF NEED: AN EXPANDING REGULATORY CONCEPT, 155-944 (1978).

unnecessary hospital, which existed in this case, was not only a brief one in Missouri, it has now been eliminated in virtually the entire country.[8]

Furthermore, while this case arose under the original Health Planning Act of 1974, the Act was extensively amended in 1979. *See* 93 Stat. 593. Although the 1979 amendments are relevant in illuminating the intent of Congress, this case was decided by the Court of Appeals under the original 1974 Act, not the subsequent 1979 Act.[9]

In an attempt to magnify the significance of the decision below, petitioner asserts that there are two cases currently pending "presenting similar or related questions." (Pet. at 10). In a sector of the economy which, according to petitioner, "accounts for almost one-tenth of the nation's total GNP" (Pet. at 8), two cases hardly constitute a groundswell of litigation. Even this number is an overstatement, however, because each of the two actions involves a variety of issues and may ultimately be decided on grounds which are of no relevance to this case.[10]

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[8] This is not surprising, since enactment of certificate of need legislation is a prerequisite to obtaining federal funds. See note 6 *supra*.

[9] Although petitioner cites to the 1979 amendments, as discussed in Section III.A. *infra*, the Court of Appeals restricted its decision to the original 1974 Act, "Public Law 93-641." (App. 1a).

[10] In Huron Valley Hospital, Inc. v. City of Pontiac, 466 F. Supp. 1301 (E.D. Mich. 1979), *appeal docketed*, No. 79-1265 (6th Cir. May 16, 1979), summary judgment was granted to defendants on three different grounds, only one of which was implied repeal. (Pet. at 27). In North Carolina v. P.I.A. Asheville, Inc., Civ. No. A-C-80-29 (W.D.N.C., filed Feb. 22, 1980), all proceedings have been stayed pending final action by the state on a certificate of need application filed by defendants for transfer of ownership of their hospitals. In addition, only one of the three grounds alleged for dismissal in defendants' motion for judgment on the pleadings involves implied repeal. (Pet. at 27-28).

Moreover, the one decision which has been rendered is in full accord with the Court of Appeals in this case. In Huron Valley Hospital, Inc. v. City of Pontiac, 466 F. Supp. 1301, 1312 (E.D. Mich. 1979), Judge Cornelia G. Kennedy, now serving on the Sixth Circuit,

Petitioner also alleges that the decision below will have widespread impact on a variety of matters which, upon analysis, are of only the most tangential relevance. (Pet. at 10-15). "Appropriateness reviews"[11] and Professional Standards Review Organizations[12] are unrelated matters which were neither presented to nor passed upon by the Court of Appeals and are not now before this Court. Neither are the so-called "learned profession" exemption,[13] the *Parker* v. *Brown* state action doctrine,[14] the interstate commerce requirement of the Sherman

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ruled that in enacting the Health Planning Act of 1974, Congress intended a "partial repeal of the antitrust laws." The court entered summary judgment for the defendants.

[11] Petitioner asserts that under the Eighth Circuit's decision, HSA "appropriateness reviews" can be used to shield all manner of private activity "—no matter how anticompetitive—which ostensibly serves the goals of this program." (Pet. at 11). Petitioner assumes that the Court of Appeals conferred a blanket immunity for any conduct which purports to be related to the Health Planning Act of 1974, but as described *infra,* no such immunity has been conferred. See Section III.C.

[12] Petitioner asserts that "the rationale utilized in this case could readily be used to support the contention that the PSRO legislation, like the [Health] Planning Act, creates a blanket exemption from antitrust. . . ." (Pet. at 11). As explained in Section III.C. *infra,* the Court of Appeals did not create a blanket exemption in this case. Moreover, any repeal of antitrust which may be implicit in the PSRO legislation must depend upon the language and legislative history of that law.

[13] Petitioner argues that the decision of the Eighth Circuit will impair the effect of this Court's treatment of "learned professions" in Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975), and National Soc'y of Professional Engineers v. United States, 435 U.S. 679 (1978). (Pet. at 13). The issue of "learned professions" was never before the courts below because there has never been a claim of such an exemption in this case.

[14] Petitioner contends that this Court has been in the process of narrowing the state action "exemption" of Parker v. Brown, 317 U.S. 341 (1943), and that the decision of the Eighth Circuit will undermine this effort. (Pet. at 13). Putting aside the question of whether *Parker* has been narrowed or simply refined by subsequent decisions, the Court of Appeals did not rule on the state action doctrine, pointing out

Act[15] or the McCarran-Ferguson Act.[16] Petitioner's attempts to paint the decision below as governing the broadest spectrum of antitrust and administrative law are without merit. The only issue presented is whether the Health Planning Act of 1974 impliedly repealed the antitrust laws with regard to the specific conduct challenged in this case.

II. The Health Planning Act of 1974 Is Irreconcilable With—"Repugnant" to—the Antitrust Laws in the Circumstances of this Case

The doctrine of implied repeal of the antitrust laws was judicially created to resolve conflicts between statutory systems and the antitrust laws. It has been called a "shorthand verbalization of common sense." *Cavanagh Communities Corp.* v. *New York Stock Exchange,* 422 F. Supp. 382, 385 (S.D.N.Y. 1976). The Court of Appeals held that, with regard to the conduct alleged in this case, the Health Planning Act of 1974

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explicitly that it was not involved in this case. (App. 8a). See also Section III.C. *infra.*

[15] Petitioner suggests that the decision below will undercut this Court's decisions on interstate commerce because even though an antitrust defendant may be engaged "in commerce," it may nonetheless prevail if it can prove repeal. (Pet. at 13-14). This is self-evident, and in no way detracts from the standards governing the commerce requirement. Interstate commerce and implied repeal are separate issues, and interstate commerce was not raised before the Court of Appeals.

For this reason, petitioner's suggestion that the decision below would "effectively undo" the ruling in Hospital Building Co. v. Trustees of Rex Hospital, 425 U.S. 738 (1976), is unsound. This Court's decision in *Rex Hospital* was confined to the issue of interstate commerce. 425 U.S. at 747 n.5. Moreover, petitioner's assertion that the conduct subsequently invalidated in *Rex Hospital* would have been "shielded" by the decision of the Court of Appeals in this case erroneously assumes that the Court below conferred "blanket" immunity, covering even such acts as the bad-faith tactics, frivolous litigation and malicious publicity alleged in *Rex Hospital.* As described hereafter, no such blanket immunity was conferred in this case. See Section III.C. *infra.*

[16] Although petitioner asserts that the decision of the Court of Appeals impairs the effect of this Court's decisions regarding the McCarran-Ferguson Act, 15 U.S.C. § 1012, the Eighth Circuit specifically held that the Act is not applicable to this case. (App. 15a). Although BCA does not agree, it is not seeking review of that determination in this Court.

impliedly repealed the antitrust laws because its encouragement of private participation in federal health care cost containment efforts is irreconcilable with antitrust and it was the intent of Congress that such conduct should not be subject to antitrust attack.

The antitrust laws, which condemn combinations or conspiracies in restraint of trade, are so antagonistic to the Health Planning Act's provisions for cooperative participation by private parties that the two are plainly repugnant to one another. The Court of Appeals determined that, in the context of this case, an irreconcilable conflict with antitrust is created by the Health Planning Act's specific provisions "for voluntary cooperation and assistance of private entities and persons in the community and health care market." (App. 7a). It held that if private entities cooperating with Health Systems Agencies "to achieve the goals of the Act were liable or might be liable under the antitrust laws for their action, then . . . the accomplishment of the purpose of the goals of the Act would be effectively foreclosed." (App. 8a).

The Blue Cross conduct here comes within the Act, which directs each HSA to implement its Health Systems Plan with the assistance of individuals and non-government entities.[17] 42 U.S.C. § 300*l*-2(c)(1); S. Rep. No. 93-1285, 93d Cong., 2d Sess., *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7888. The Act provides that "[s]ince the health care provider is one of the most important participants in any health care delivery system, . . . it is imperative that the provider be encouraged to play an active role in developing health policy at all levels." 42 U.S.C. § 300k(a)(5). The Act thus encourages entities such as Blue Cross to take actions consistent with the stated goals and purpose of the Act.

In creating the 1974 Act, Congress found that "the need for additional hospital beds in the nation has virtually dis-

[17] MAHSA also found the voluntary cooperation of parties such as Blue Cross important to the implementation of its Plan. (HSP 1978-1982 at 6-22).

appeared," S. Rep. No. 93-1285, 93d Cong., 2d Sess., *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7864, and that the growing surplus of hospital beds had become a critical national problem. *Id.* at 7878-7879; 42 U.S.C. § 300k(a)(4). MAHSA's studies confirmed that the Kansas City area in particular was suffering from a surplus of hospital beds. (HSP 1978-1982 at 6-19 and 7-3).

Consistent with these findings, the Blue Cross Plan Board of Trustees unilaterally adopted the following criteria in order to contract with hospitals on January 1, 1976:

> "The hospital must meet a clearly evident need for health care services in its defined service area. Health care institutions and institutional services shall be approved, and/or if required by law, certified as necessary, by the designated planning agency or area-wide health planning agency respectively; or, when effective, by the designated State Agency as provided for in Public Law 93-641, the 'National Health Planning and Resources Development Act of 1974.'"

(Petitioner's Court of Appeals Brief at 11). This policy does no more than incorporate national policy. Indeed, what else could Blue Cross have done — its only alternative was to flout the express objectives of the Health Planning Act of 1974. Petitioner's claim is that by doing exactly what was expected under the Act — by acting consistently with its underlying purpose and goals — Blue Cross could and did violate the antitrust laws. The clear repugnancy between the two statutory schemes is brought into sharp focus by nothing so well as this very claim.

The Court of Appeals properly concluded that Congress intended an implied repeal of the antitrust laws in the circumstances of this case:

> "The legislative history indicates to this Court that any attempts by companies such as these defendants to reduce costs and duplication were to be welcomed and were considered essential to a successful program of cost reduction." (App. 12a).

The Court of Appeals noted the Senate Committee Report accompanying the Health Planning Act of 1974, which found that there had been a failure in the health care industry to "respond to classic market place forces" (App. 11a), and that each Health Systems Agency would be directed by the Act "to seek to implement its long-range goal Plan and short-term priorities Plan with the assistance of individuals and public and private entities in its health area." (App. 13a).

The conclusion of the Court of Appeals was reinforced by the statement of Representative Paul Rogers, Chairman of the Subcommittee on Health and the Environment of the House Committee on Interstate and Foreign Commerce, in the debates concerning the 1979 amendments to the Health Planning Act. Representative Rogers clearly articulated the congressional intent to override antitrust in the case of cooperation by private entities:

> "Although Public Law 93-641 [the Health Planning Act of 1974] contains no specific exemption from the antitrust laws, an analysis of the activities required of HSA's and providers indicates that Congress sanctioned actions which might otherwise be in violation of our antitrust laws. The intent of Congress was that HSA's and providers who voluntarily work with them in carrying out the HSA's statutory mandate should not be subject to the antitrust laws. *If they were, Public Law 93-641 simply could not be implemented.* Congressional Record House, No. 18 Part 1, p. H11962-H11963." (App. 14a-15a) (emphasis added).[18]

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[18] In the Court of Appeals the Federation of American Hospitals (identified in note 2 *supra*) argued that Representative Rogers' remarks did not support the Court's conclusion because he assertedly was referring to immunity only for *hospitals* as "providers" and only in instances where there is state certificate of need legislation. (Federation of American Hospitals Brief at 20-21). When the remarks are read in full context, however, it becomes clear that Representative Rogers referred to hospitals only as an "example" of provider cooperation and referred to the interaction of the Health

The courts below were correct in concluding that the antitrust laws were intended to be impliedly repealed in the circumstances of this case. What Blue Cross is charged with doing is nothing more than what was intended by Congress.

III. Petitioner's Arguments Are Without Merit

A. The Health Planning Act of 1974 Is Premised Upon the Elimination of Competition for Inpatient Services

The fulcrum of petitioner's case is the principle that "the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress." *Northern Pacific Railway Co.* v. *United States,* 356 U.S. 1, 4 (1958). (Pet. at 7-8). In fact, Congress found exactly the opposite: that the unrestrained interaction of competitive forces does *not* serve the public interest in the peculiar circumstances of inpatient hospital services and should *not* be encouraged because "the health care industry does not respond to classic marketplace forces." S. Rep. No. 93-1285, 93d Cong., 2d Sess., *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7878.[19] The conclusion of Congress was, essentially, that the last thing this country needs is competition in the form of building more hospital beds.[20] (See also Section IV *infra*).

Planning Act of 1974 and certificate of need legislation as only one indication of Congress' intent that there be an implied repeal.

[19] *Cf.* Latin America/Pacific Coast S.S. Conf. v. FMC, 465 F.2d 542, 546 (D.C. Cir. 1972) ("There are . . . particular economic or social objectives sought by Congress which are unattainable through the free forces of competition.")

[20] This conclusion was reaffirmed in recent congressional hearings where Charles Schultz, Chairman of the Council of Economic Advisors, remarked that the health care industry lacks most of the characteristics of a free market economy. He explained that "in the case of hospital costs, the buyer and seller are the same person" since most decisions are made by the physician.

> "Indeed, if this had been the major form that our industries had taken over the past 200 years, you would never have seen Adam Smith's 'Wealth of Nations' published because it would not make any sense." *Hearings on S. 570 Before the Subcomm. on*

B. The 1979 Amendments to the Health Planning Act of 1974 Preclude Competition For Inpatient Services

Petitioner maintains that Congress could not have intended to repeal the antitrust laws with the Health Planning Act of 1974 because the 1979 amendments to the Act indicate a congressional intention that "competition is to play a significant role in the delivery of health care services." (Pet. at 9). This is in error because such statements in the 1979 amendments pertain only to *outpatient* services, not to the *inpatient* services here.

The key to this case is that Congress has drawn a critical distinction between inpatient and outpatient care in formulating the Health Planning Act and its amendments.

It is correct that the intent of Congress in the 1974 Act was elucidated in the 1979 amendments, but not to the effect which petitioner suggests. In 1979 Congress explicitly *rejected* competition as an appropriate mechanism for allocating *inpatient* services, while recognizing that competition in *outpatient* services should be encouraged to the extent it is found to result in the appropriate allocation of such services. As petitioner points out, Congress called for "[t]he strengthening of competitive forces in the health services industry" (Pet. at 9), but this is only half the quotation. What Congress called for was "[t]he strengthening of competitive forces in the health services industry wherever competition and consumer choice can constructively serve, *in accordance with subsection (b) of this section,* to advance the purposes of quality assurance, cost effectiveness, and access." 42 U.S.C. § 300k-2(a)(17) (emphasis added).[21]

Health and Scientific Research of the Senate Comm. on Labor and Human Resources, 96th Cong., 1st Sess. 110 (1979).

A similar note was sounded by HEW Secretary Joseph Califano, Jr., who stated flatly that "the traditional competitive forces of the marketplace do not operate in the hospital industry." *Id.* at 72.

[21] See also 42 U.S.C. § 300*l*-2(a)(5), which calls for "preserving and improving, *in accordance with section 300k-2(b) of this title,* competition in the health service area." (Emphasis added).

National Gerimedical totally misapprehends subsection 300k-2(b) in the 1979 amendments, which, in its three paragraphs, makes clear that Congress was calling for competition only with regard to outpatient services, *not* with regard to inpatient hospital bed construction.

The first paragraph of subsection 300k-2(b) is a finding on the effects of competition:

> "(1) The Congress finds that the effect of competition on decisions of providers respecting the supply of health services and facilities is diminished. The primary source of the lessening of such effect is the prevailing methods of paying for health services by public and private health insurers, *particularly for inpatient health services* and other institutional health services. *As a result, there is duplication and excess supply of certain health services and facilities, particularly in the case of inpatient health services.*" 42 U.S.C. § 300k-2(b)(1) (emphasis added).

The second and third paragraphs of subsection 300k-2(b) distinguish between services where competition should *not* be encouraged, specifically including inpatient services, and services where competition should be encouraged:

"(2) For health services, *such as inpatient health services* and other institutional health services, *for which competition does not or will not appropriately allocate supply* consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the exercise of their functions under this subchapter take actions (where appropriate to advance the purposes of quality assurance, cost effectiveness, and access and the other purposes of this subchapter) to allocate the supply of such services."

"(3) For the health services *for which competition appropriately allocates supply* consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the performance of their functions under this subchapter give priority (where appropriate to advance the purposes of quality assurance, cost effectiveness, and access) to actions which would strengthen the effect of competition on the supply of such services."

42 U.S.C. § 300k-2(b)(2),(3) (emphasis added).

Thus, competition, the bedrock of the Sherman Act, has emerged under the Health Planning Act as the bete noire for inpatient services, which have become overabundant, and "for which competition does not or will not appropriately allocate supply."[22]

In a word, petitioner has pointed only to paragraph (b)(3), which is irrelevant (Pet. at 9), and has never mentioned paragraph (b)(2), which relates to the inpatient health services here.

C. The Court Below Did Not Grant A "Blanket Exemption"

Petitioner states over and over that the Court of Appeals improperly created a "blanket exemption" from the antitrust laws. (Pet. at 7, 8, 15, 16, 19, 22, 24; *cf.* 11, 12).[23] Nowhere does "blanket" appear in the Court of Appeals' opinion. On the contrary, the implied repeal was confined. The Court of Appeals held only that "the doctrine of implied immunity applies to Blue Cross' voluntary cooperation with the congressionally designated HSA in requiring [National Gerimedical] to obtain need approval from MAHSA prior to applying for a Blue Cross membership contract." (App. 15a). The Court rested its holding on

> "the specific provisions of the National Health Planning and Resources Development Act for voluntary cooperation

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[22] Petitioner cites a commentator (Pet. at 9) to the effect that it would be "anomalous" to interpret "a statute designed to make use of competition" in such a way as "to invalidate the means to enforce it." Miller, *Antitrust and Certificate of Need: Health Systems Agencies, The Plan Act, and Regulatory Capture,* 68 GEORGETOWN L.J. 873, 891 (1980). This commentator *recognizes* that subsection (b) serves to "exclude inpatient health services" from competition, but complains that so long as inpatient services are excluded, "the ability of planning agencies to strengthen competitive forces will be narrow in scope." *Id.* Having said this, the commentator criticizes the supposed anomaly, but it is misleading for petitioner to suggest that this view reflects the intent of Congress when the opposite is true.

[23] The district court did refer to a "blanket exemption." (App. 32a). Whether or not the district court actually applied such an exemption, however, is not the issue because the Court of Appeals never even mentioned "blanket" exemptions.

> and assistance of private entities and persons in the community and health care market. While the doctrine of implied immunity is to be used sparingly and only when necessary, *Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659 (1975), these provisions make the instant situation one well-suited for its use." (App. 7a).

Indeed, the Court of Appeals held that implied immunity arises only if there is "a clear repugnancy between the antitrust laws and the specific conduct at issue . . . ." (App. 7a). It relied upon this Court's opinion in *United States* v. *National Association of Securities Dealers,* 422 U.S. 694, 734 (1975), for the proposition that:

> "Implied immunity can be found in 'particular and discrete instances to assure that the federal agency entrusted with regulation in the public interest could carry out that responsibility free from the disruption of conflicting judgments that might be voiced by courts exercising jurisdiction under the antitrust laws.' " (App. 10a-11a).

Petitioner argues that implied immunity "must be narrowly limited to that which is actually required to make the federal regulatory scheme work" (Pet. at 23), but this is precisely the test which the Court of Appeals applied. Petitioner argues further that the Court below "went out of its way to find a conflict" (Pet. at 24), when in fact there was a finding that immunity was necessary to permit the Act to be implemented. (App. 7a, 15a). Indeed, there was no need for the Court of Appeals to find a "blanket exemption" in the particularly compelling factual circumstances of this case. Any statutory scheme, even one that does not create a total exemption from antitrust, can confer implied immunity from antitrust claims in particular instances, and this is all that the Court of Appeals held.[24]

---

[24] Petitioner asserts the doctrine of "expressio unius est exclusio alterius" for the proposition that Congress intended immunity only for members or employees of an HSA, since this is specifically provided for in the Act. Petitioner's reliance on this doctrine is erroneous, however, because the inclusion of an express immunity provision in a statute does not preclude a finding of implied immunity. *See* United States v. National Ass'n of Securities Dealers, 422 U.S. 694, 720

D. Petitioner's Additional Arguments Are Invalid

Petitioner also argues that there should be no implied repeal because the Health Planning Act of 1974 assertedly involves "no federal regulatory scheme whatever" and because there purportedly was "no governmental oversight whatever." (Pet. at 16, 20). Neither of these arguments has any validity.

First, there *is* a regulatory scheme at work here. (See App. 9a-10a). Petitioner's contention is that because Missouri had no state certificate of need legislation in effect during the period when Blue Cross rejected its application, the Health Planning Act was serving no regulatory function in Missouri at that time. Between June 30, 1976 and the August, 1979 passage of Missouri's certificate of need legislation (effective October 1, 1980), Missouri had no need review mechanism,[25] but the fact that a state may not have enacted certificate of need legislation at a particular time does not detract from the applicability of the Health Planning Act of 1974 or from the duties of the HSA's operating in that state, including reduction of "documented inefficiencies" and implementation of a Health Systems Plan. 42 U.S.C. § 300*l*-2(a)(5). It does not mean that there would be "no federal regulatory scheme" in such a state, but only that there would not be *state* involvement in the scheme. MAHSA, the federally-designated HSA, was fulfilling its regu-

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(1975) (immunity inferred under § 22(f) despite inapplicability of express immunity in § 22(d) of Investment Company Act of 1940); Pan American World Airways, Inc. v. United States, 371 U.S. 296, 305-310, 320 (1963) (implied immunity applied to transactions that could not be immunized under express provision of § 414 of the Federal Aviation Act).

Petitioner also cites certain Business Review Clearances of the Department of Justice (Pet. at 10) which express the opinion that the Health Planning Act does not create "a complete antitrust exemption." Petitioner fails to note that these letters *granted* most of the clearances requested. Moreover, the language quoted referred to agreements "among competing hospitals" (Pet. at 28, 29-30), and is of no relevance to the conduct passed upon by the Court of Appeals.

[25] Prior to the 1974 Act, a moratorium on hospital construction already existed in the Kansas City area because of a surplus of beds. S. Rep. No. 93-1285, 93d Cong., 2d Sess., *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7852.

latory function at all relevant times and National Gerimedical cannot escape the provisions of the Act merely because the State of Missouri had hesitated in enacting its own legislation.

The Court of Appeals pointedly disposed of this argument, saying that National Gerimedical's "emphasis upon the fact that Missouri was not a participating state . . . misses the focus of the doctrine of implied immunity. The doctrine should not be confused with the state action exemption to the antitrust laws as articulated in *Parker* v. *Brown,* 317 U.S. 341 (1943)." (App. 8a, see also App. 9a).

Second, petitioner's argument that there was "no government oversight whatever" is equally defective—there was extensive government oversight. MAHSA, faithful to its federal mandate, made a reasoned determination, following an investigation and public hearings, that additional hospital beds were unwarranted in the Kansas City area. (HSP 1978-1982 at 7-3). Blue Cross lent its support to the achievement of MAHSA's goals.[26] Not only were MAHSA's investigation and plan required by the Health Planning Act of 1974, but every step of MAHSA's procedure was carried out pursuant to the detailed requirements of the Act.[27]

* * *

The holding that the antitrust laws have been impliedly repealed in the circumstances of this case has been unanimous. All three judges on the panel of the Court of Appeals agreed with the district judge. A petition for rehearing *en banc* was denied. The conclusion of every judge has been the same —Blue Cross' determination not to contract with petitioner does not violate the Sherman Act because the Health Planning Act of 1974 impliedly repeals its application in these circumstances.

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[26] Although petitioner complains that there was "no mechanism for administrative review" (Pet. at 21), it could have sought reconsideration of MAHSA's determination of hospital bed oversupply. *See* 42 U.S.C. § 300*l*-2(b)(2). In fact, petitioner never approached MAHSA at all.

[27] Specifically, MAHSA was required to assemble and analyze data concerning the status of health and health care in its area; the number, type and location of health care facilities; the patterns of utilization of these facilities; and the effect of the area's health care

IV. Petitioner Is Seeking to Undermine Congress' Purpose to Control Hospital Costs

At the heart of this case is the control of hospital costs. Pitted against each other are the national interest in arresting inflation attributable to hospital overbedding and the economic self-interest of a single hospital, in circumstances where Congress has recognized that the two cannot be reconciled. (See Sections III.A. and III.B. *supra*). Yet National Gerimedical, which is seeking to increase the cost of health care, accuses Blue Cross and MAHSA of conspiring to undermine the public interest. (Pet. at 8-9).

The goals of the Health Planning Act of 1974, reflected in the HSA's statutory purpose, are to restrain increases in hospital costs and eliminate "unnecessary duplication of health resources." 42 U.S.C. § 300*l*-2(a)(3), (4). In passing the 1974 Act, Congress cited evidence that by 1975, over 67,000 unneeded hospital beds would be in operation throughout the United States. S. Rep. No. 93-1285, 93d Cong., 2d Sess., *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7878-79. In enacting the 1979 amendments, Congress cited estimates indicating that by 1979 the oversupply of hospital beds had reached 130,000. S. Rep. No. 96-96, 96th Cong., 1st Sess. 8, *reprinted in* [1979] U.S. Code Cong. & Ad. News 1306, 1313. One hundred and twenty of those beds were placed by National Gerimedical.

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delivery system on the health of area residents. 42 U.S.C. § 300*l*-2(b)(1). In formulating its plan, MAHSA was required to consider the recommended national guidelines for health planning policy issued by the Secretary of Health and Human Resources, the priorities set forth in the Health Planning Act, and the data which it was required to assemble. Its plan was required to include a statement of goals describing the type of health care system sought to be achieved, and these goals were expected to be responsive to the needs and resources of the area and to take into account the national guidelines for health planning policy. 42 U.S.C. § 300*l*-2(b)(2). Before establishing its Health Systems Plan, MAHSA was required to conduct a public hearing and give interested persons an opportunity to submit their views orally and in writing. In addition, it was required to establish an annual implementation plan, subject to yearly review. *Id.* Moreover, all of the activities of MAHSA were subject to continuous review by the United States Department of Health and Human Services. 42 U.S.C. § 300*l*-4.

CONCLUSION

For the reasons described above, we respectfully request that the petition for a writ of certiorari be denied.

December 22, 1980

Respectfully submitted,

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APPENDIX

STATUTORY PROVISIONS INCLUDED

Section 1 of the Sherman Act, 15 U.S.C. § 1, provides in pertinent part:

> "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. . . ."

Section 2 of the Sherman Act, 15 U.S.C. § 2, provides in pertinent part:

> "Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony. . . ."

The relevant provisions of the National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300k *et seq.* provide in pertinent part:

Section 300k(a):

> "The Congress makes the following findings:
>
> (1) The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government.
>
> (2) The massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources.
>
> (3) The many and increasing responses to these problems by the public sector (Federal, State, and local)

and the private sector have not resulted in a comprehensive, rational approach to the present—

(A) lack of uniformly effective methods of delivering health care;

(B) maldistribution of health care facilities and manpower; and

(C) increasing cost of health care.

(4) Increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care for inpatient hospital care.

(5) Since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns of the provider if it is to achieve meaningful results; and, thus, it is imperative that the provider be encouraged to play an active role in developing health policy at all levels.

(6) Large segments of the public are lacking in basic knowledge regarding proper personal health care and methods for effective use of available health services."

Section 300k(b):

"In recognition of the magnitude of the problems described in subsection (a) of this section and the urgency placed on their solution, it is the purpose of this Act to facilitate the development of recomendations for a national health planning policy, to augment areawide and State planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy."

Section 300k-2(a):

"The Congress finds that the following deserve priority consideration in the formulation of national health planning goals and in the development and operation of Federal, State, and area health planning and resources development programs:

* * *

(17) The strengthening of competitive forces in the health services industry wherever competition and consumer choice can constructively serve, in accordance with subsection (b) of this section, to advance the purposes of quality assurance, cost effectiveness, and access."

Section 300k-2(b):

"(1) The Congress finds that the effect of competition on decisions of providers respecting the supply of health services and facilities is diminished. The primary source of the lessening of such effect is the prevailing methods of paying for health services by public and private health insurers, particularly for inpatient health services and other institutional health services. As a result, there is duplication and excess supply of certain health services and facilities, particularly in the case of inpatient health services.

(2) For health services, such as inpatient health services and other institutional health services, for which competition does not or will not appropriately allocate supply consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the exercise of their functions under this subchapter take actions (where appropriate to advance the purposes of quality assurance, cost effectiveness, and access and the other purposes of this subchapter) to allocate the supply of such services.

(3) For the health services for which competition appropriately allocates supply consistent with health sys-

tems plans and State health plans, health systems agencies and State health planning and development agencies should in the performance of their functions under this subchapter give priority (where appropriate to advance the purposes of quality assurance, cost effectiveness and access) to actions which would strengthen the effect of competition on the supply of such services."

Section 300*l*-1(b)(3)(C):

"The membership of the governing body and the executive committee (if any) of an agency shall meet the following requirements:

* * *

(ii) The remainder of the members shall be residents of, or have their principal place of business in, the health service area served by the agency who are providers of health care and who represent (I) physicians (particularly practicing physicians), dentists, nurses, optometrists, podiatrists, physician assistants, and other health professionals, (II) health care institutions (particularly hospitals, long-term care facilities, rehabilitation facilities, alcohol and drug abuse treatment facilities, and health maintenance organizations), (III) health care insurers, (IV) health professional schools, (V) the allied health professions, and (VI) other providers of health care. Not less than one-half of the providers of health care who are members of the governing body or executive committee of a health systems agency shall be direct providers of health care (as described in section 300n(3) of this title) and of such direct providers of health care, at least one shall be a person engaged in the administration of a hospital."

Section 300*l*-2(a):

"For the purpose of—

(1) improving the health of residents of a health service area,

(2) increasing the accessibility (including overcoming geographic, architectural, and transportation barriers), acceptability, continuity, and quality of the health services provided them,

(3) restraining increases in the cost of providing them health services,

(4) preventing unnecessary duplication of health resources, and

(5) preserving and improving, in accordance with section 300k-2(b) of this title, competition in the health service area, each health systems agency shall have as its primary responsibility the provision of effective health planning for its health service area and the promotion of the development within the area of health services, manpower, and facilities which meet identified needs, reduce documented inefficiencies, and implement the health plans of the agency."

Section 3007-2(c):

"A health systems agency shall implement its HSP and AIP, and in implementing the plans it shall perform at least the following functions:

(1) The agency shall seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area."

No. 80-802

FILED

SEP 22 1980

MICHAEL RODAK, JR., CLERK

In the Supreme Court of the United States

October Term, 1980

NATIONAL GERIMEDICAL HOSPITAL
AND GERONTOLOGY CENTER,
Petitioner,

vs.

BLUE CROSS OF KANSAS CITY AND
BLUE CROSS ASSOCIATION,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE
EIGHTH CIRCUIT

BRIEF OF RESPONDENT BLUE CROSS OF KANSAS CITY IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

The question presented is whether, under the unique facts of this case, the National Health Planning and Resources Development Act of 1974, considered in its entirety, expresses the intent of Congress that the antitrust laws should not apply to the conduct of private parties that decline to contract with a new hospital built without need approval in contravention of a Health Systems Plan developed under the Act, where that conduct is specifically authorized and encouraged by the Act and assists implementation of the Act.

TABLE OF CONTENTS

Statutory Provisions Involved 2

Statement of the Case 2

Reasons Why the Writ Should Be Denied—

I. The Decision Below Does Not Raise the Question Presented in the Petition 4

II. The Decision Below Is of Limited Precedential Value Because It Was Based Upon the Unique Factual Circumstances of This Case 7

A. The Decision Below Does Not Displace Competition in the Health Care Industry With Unsupervised Private Action 10

B. Review of the Decision Below Will Not Clarify the General Ground Rules Governing Antitrust Liability in the Health Care Industry 12

C. The Decision Below Does Not Impair Other Decisions of This Court With Respect to the Health Care Industry 15

III. The Decision Below Properly Applies Settled Principles of Implied Repeal in a Narrow Factual Context and Is Fully Consistent With Prior Decisions of This Court 16

A. The Decision Below Does Not Conflict With Decisions of This Court by Extending the Doctrine of Implied Repeal to Statutes Involving No Federal Regulatory Scheme 17

B. The Decision Below Does Not Conflict With Decisions of This Court by Extending the Doctrine of Implied Repeal to Private Voluntary Conduct Subject to No Governmental Oversight 21

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C. The Decision Below Properly Follows and Applies the Principles Governing Implied Repeal Established by This Court 22

Conclusion 26

Apendix A—Opinion of the Eighth Circuit Court of Appeals 1a

Appendix B—State Certificate of Need Legislation and Section 1122 Agreements 17a

TABLE OF AUTHORITIES

Cases

California v. Federal Power Commission, 369 U.S. 483 24

Carnation Company v. Pacific Westbound Conference, 383 U.S. 216 24

Davis v. United States, 417 U.S. 333 (1974) 20

Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc., 365 U.S. 127 (1961), *rehearing denied*, 365 U.S. 875 (1961) 9

Exxon Corp. v. Governor of Maryland, 437 U.S. 117 (1978), *rehearing denied*, 439 U.S. 884 (1978) 9

Federal Maritime Commission v. Seatrain Lines, Inc., 411 U.S. 726 (1973) 21,23,24

Gordon v. New York Stock Exchange, Inc., 422 U.S. 659 (1975) 18, 19, 21, 23

Group Life & Health Insurance Company v. Royal Drug Company, 440 U.S. 205 (1979), *rehearing denied*, 441 U.S. 917 (1979) 15-16

Hospital Building Company v. Trustees of Rex Hospital, 425 U.S. 738 (1976) 15

Hughes Tool Company v. Trans World Airlines, Inc., 409 U.S. 363 (1973), *rehearing denied*, 410 U.S. 975 (1973) 25

Huron Valley Hospital, Inc. v. City of Pontiac, 466 F. Supp. 1301 (E.D. Mich. 1979) 9, 13, 19, 20
Kimbrough v. United States, 364 U.S. 661 (1961) 20
Lafayette v. Louisiana Power & Light Company, 435 U.S. 389 (1978) 9
Lamb Enterprises, Inc. v. Toledo Blade Company, 461 F.2d 506 (6th Cir.), *cert. denied*, 409 U.S. 1001 (1972) 9
MCI Communications Corporation v. American Telephone & Telegraph Company, 462 F. Supp. 1072 (N. D. Ill. 1978), *aff'd*, 594 F.2d 594 (7th Cir. 1978), *cert. denied*, 440 U.S. 971 (1979) 21
National Railroad Passenger Corporation v. National Association of Railroad Passengers, 414 U.S. 453 (1974), *rehearing denied*, 415 U.S. 952 (1974) 24
North Carolina v. P.I.A. Asheville, Inc. (Civ. No. A-C-80-29) 13
Oahu Gas Service, Inc. v. Pacific Resources, Inc., 460 F. Supp. 1359 (D. Hawaii 1978) 21
Pan American World Airways, Inc. v. United States, 371 U.S. 296 (1963) 21, 23, 25
Parker v. Brown, 317 U.S. 341 (1943) 9
Ricci v. Chicago Mercantile Exchange, 409 U.S. 289 (1973) 21
Sanchez v. Borras, 283 U.S. 798 (1931) 24
Silver v. New York Stock Exchange, 373 U.S. 870 (1963), *rehearing denied*, 375 U.S. 870 (1963) 21
Sound, Inc. v. American Telephone & Telegraph Company, No. 80-1047 (8th Cir., August 25, 1980) 19, 20
United Mine Workers v. Pennington, 381 U.S. 657 (1965) 9
United States v. Borden Company, 308 U.S. 188 (1939) 21, 23, 24

United States v. National Association of Securities Dealers, Inc., 422 U.S. 694 (1975) 7, 21, 23, 25
United States v. Philadelphia National Bank, 374 U.S. 321 (1963) 21, 23
Wisconsin Electric Company v. Dumore Company, 282 U.S. 813 (1930) 24

STATUTES

15 U.S.C. § 1 2
15 U.S.C. § 2 2
42 U.S.C. §§ 300k *et seq.* ..... passim
42 U.S.C. § 1320a-1 8

OTHER

MEDICINE IN THE PUBLIC INTEREST, INC., CERTIFICATE OF NEED: AN EXPANDING REGULATORY CONCEPT 3 (1976) 8
S. Rep. No. 93-1285, 93d Cong., 2d Sess., 1974 U.S. Code Cong. & Ad. News 7842 11

No. 80-802

In the Supreme Court of the United States

October Term, 1980

NATIONAL GERIMEDICAL HOSPITAL
AND GERONTOLOGY CENTER,
Petitioner,

VS.

BLUE CROSS OF KANSAS CITY AND
BLUE CROSS ASSOCIATION,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE
EIGHTH CIRCUIT

BRIEF OF RESPONDENT BLUE CROSS OF KANSAS CITY IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

Respondent Blue Cross of Kansas City respectfully requests that this Court deny the Petition for Writ of Certiorari seeking review of the Eighth Circuit Court of Appeals' Opinion in this case. Blue Cross of Kansas City concurs in petitioner's statements under the headings *Opinions Below* and *Jurisdiction.*

STATUTORY PROVISIONS INVOLVED

The statutory provisions involved in this case include Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2 (Petition at 2), and the entire National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300k *et seq.*

STATEMENT OF THE CASE

Respondent Blue Cross of Kansas City adopts petitioner's factual statement, with the addition of the following material facts:

In 1973, Missouri entered into an Agreement pursuant to Section 1122 of the Social Security Act, 42 U.S.C. § 1320a-1, which required, *inter alia,* that state approval be granted prior to commencement of new hospital construction. That Agreement was terminated on June 30, 1976, so that no agency was responsible under state law for limiting or controlling hospital expansion. (628 F.2d at 1053; App. A at 6a).

Mid-America Health Systems Agency (MAHSA) was designated by the Secretary of Health, Education and Welfare (HEW) in 1976 as the regional planning agency for the Kansas City metropolitan area under the National Health Planning and Resources Development Act of 1974 (the Health Planning Act). (628 F.2d at 1052-1053; App. A at 5a). MAHSA had as its responsibility "the provision of effective health planning for its health service area." 42 U.S.C. § 300l-2(b). The Act states that the local agency shall develop a Health Systems Plan (HSP) which shall be implemented "with the assistance of individuals and public and private entities." 42 U.S.C. § 300l-2. In developing its HSP, MAHSA determined that additional

hospital beds were not needed in the Kansas City metropolitan area, and announced that no approval would be granted for expansion, including new hospitals. (628 F.2d at 1054; App. A at 7a-8a).

In the absence of state legislation, Blue Cross of Kansas City determined that it would follow the directives of MAHSA as the regulatory agency charged with health services planning in the Kansas City area. (628 F.2d at 1053; App. A at 6a). Accordingly, on July 21, 1976, Blue Cross of Kansas City publicly announced:

> Since the State Planning Agency no longer exists, Blue Cross of Kansas City will look to the local Health Systems Agency for approval of such capital projects. That Health Systems Agency in the Kansas City metropolitan area is the Mid-America Health Systems Agency and in the balance of our operating area, Area II Health Systems Agency. *All projects not reviewed and approved by these Health Systems Agencies will not be reimbursible by Blue Cross of Kansas City.* 628 F.2d at 1053; App. A at 7a.

This policy remained in effect until 1979, when the State of Missouri reinstated its Agreement under Section 1122 of the Social Security Act, and additionally enacted Certificate of Need legislation pursuant to the Health Planning Act. (Appendix B to Respondent's Brief). Petitioner National Gerimedical Hospital applied for a Blue Cross participating hospital contract in 1977, although it had not sought or obtained approval from MAHSA prior to beginning construction. (628 F.2d at 1052, 1054; App. A at 4a, 7a). Blue Cross of Kansas City, in compliance with its announced policy, did not offer a participating contract to petitioner because petitioner had not received MAHSA's approval. (628 F.2d at 1054; App. A at 7a).

In 1977, the year in which petitioner hospital began construction, Missouri was the only state in which health care providers were not required to obtain agency approval prior to undertaking new development. All other states and the District of Columbia required agency approval under either Section 1122 of the Social Security Act or the Health Planning Act, and such requirements have remained continuously in force. Missouri is the only state in which such a gap in state enforcement has occurred. A list of all states summarizing the status of Certificate of Need legislation and Section 1122 Agreements is contained in Appendix B to Respondent's Brief.

REASONS WHY THE WRIT SHOULD BE DENIED

I.

The Decision Below Does Not Raise the Question Presented in the Petition

Petitioner misstates the holding of the Eighth Circuit in its *Question Presented.* The question stated in the Petition is whether a selected portion of the National Health Planning and Resources Development Act of 1974 is "so inconsistent with the antitrust laws" as to create a "blanket exemption" from those laws for a concerted refusal to deal, where there was "no involvement by a state or federal agency," where there was "no state or federal mandate or supervision of the parties or conduct involved," and where the federal statute "did not expressly immunize the boycott." This question is not raised by the decision below.

In attempting to persuade this Court to grant certiorari in this case, petitioner has created an unfounded illusion that the decision below represents a sweeping,

industrywide "blanket exemption" from the antitrust laws under the Health Planning Act. But that is not what the Court of Appeals actually held at all.[1] The *holding* was that respondent is immune from antitrust liability for the specific conduct alleged by petitioner, under the particular facts of this case and applicable provisions of the Health Planning Act.[2]

This case involves only one part of the health services industry—the supply of hospital beds. The particular illegal conduct alleged is respondent's decision not to contract with a new hospital whose facility was constructed without either seeking or obtaining need approval, in direct contravention of a Health Systems Plan developed by the regional Health Systems Agency officially designated under the Health Planning Act. Further, these activities occurred during a brief interval of time prior to Missouri's enactment of legislation formally implementing the Health Planning Act in the state.[3] Finally, both the language and congressional history of the Health Planning Act demonstrate that the specific conduct involved here was expressly authorized and intended under

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1. The Petition conspicuously avoids reference to the "holding" of the court below. Instead, and in an obvious attempt to create an image that this case has far-reaching implications beyond its own facts, petitioner repeatedly refers merely to "the decision below." Petitioner's failure to recognize the very limited scope of the Court of Appeals' actual holding in this case demonstrates the fundamental error in its entire argument.

2. 628 F.2d at 1057; App. A at 16a. There is language in the *District Court's* opinion which arguably could extend beyond the facts presented. 479 F. Supp. at 1021. But the *Court of Appeals'* opinion contains no such language and in fact expressly holds to the contrary.

3. Missouri later enacted such legislation, thus rendering impossible a recurrence of the circumstances in this lawsuit. See Part II of Respondent's Brief, *infra*.

the Act.[4] These circumstances render the holding of the court below an extremely narrow one.

The Court of Appeals' opinion makes clear that its decision must be limited to the specific circumstances presented. The Court began its analysis of the implied repeal issue by stating:

> While the doctrine of implied immunity is to be used sparingly and only when necessary . . . these provisions [of the Act] make *the instant situation* one well-suited for its use.
>
> The necessity of application of the doctrine of implied immunity arises if there is (1) a clear repugnancy between the antitrust laws *and the specific conduct at issue* and (2) if the intent of Congress is that implied repeal of the antitrust laws was intended. (Emphasis added). 628 F.2d at 1054; App. A at 8a.

The Court of Appeals later emphasized that the decision applies only to its specific facts by stating its holding in these terms:

> We affirm the district court's holding; the doctrine of implied immunity applies *to Blue Cross' voluntary cooperation* with the Congressionally designated HSA *in requiring National to obtain need approval from MAHSA prior to applying for a Blue Cross member-*

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4. Congress specifically found that competition does not work in this particular part of the health services industry. Based on that finding (and others), the Act establishes a regional Health Systems Agency (HSA) whose purposes include "restraining increases in the cost of providing . . . health services," and "preventing unnecessary duplication of health resources." 42 U.S.C. § 3001-2(a). Under the Act the functions of the HSA include development of a Health Systems Plan for its appropriate region, and implementation of that plan with the assistance of individuals and public and private entities. 42 U.S.C. § 3001-2(b).

ship contract. (Emphasis added). 628 F.2d at 1057; App. A at 15a.

On other occasions throughout the opinion the Court below was careful to reiterate the limited scope of its holding.[5]

In addition to the fact that the Court of Appeals did not hold there was a "blanket exemption" from the antitrust laws, the Court specifically referred to involvement by a federally-designated agency, MAHSA. (628 F.2d at 1055; App. A at 10a). It is clear that the Eighth Circuit's holding is predicated at least in part upon the existence of a federal regulatory scheme mandating the cooperation of private parties. (628 F.2d at 1054; App. A at 8a). Thus, the question which petition attempts to present simply does not exist on the record in this case.

II.

The Decision Below Is of Limited Precedential Value Because It Was Based Upon the Unique Factual Circumstances of This Case

This case presents factual circumstances which are extremely unlikely to recur. The facts of this case arose because of a gap in state enforcement legislation in Missouri which no longer exists and which did not occur in any other jurisdiction in the country. Since at least 1977 every state other than Missouri has had continuously in force a program requiring that hospitals obtain state or

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5. For example, the Court, following settled principle, quoted from *United States v. National Association of Securities Dealers, Inc.*, 422 U.S. 694 (1975), that "implied immunity can be found in *'particular and discrete instances'* . . ." (Emphasis added). (628 F.2d at 1055; App. A at 11a). The Court later went on to note its agreement with the district court's finding of a clear repugnancy between the Act and antitrust laws because "the Act and regulatory scheme clearly call for *the action which has now become the basis of an antitrust claim.*" (Emphasis added). (628 F.2d at 1055-1056; App. A at 12a).

local certification prior to expanding facilities, either under Section 1122 of the Social Security Act, 42 U.S.C. § 1320a-1, or under the Health Planning Act.[6] Missouri had terminated its certification program under Section 1122 of the Social Security Act in 1976, and did not enact new legislation under the Health Planning Act until 1979. For a three-year period no Missouri state law required that approval be granted before new hospital facilities were built. National Gerimedical Hospital was built during this gap in state enforcement legislation. *Only* in Missouri was there a hiatus in state enforcement,[7] and *only* in Missouri could a hospital have been built without obtaining prior certification from a state or local planning agency.

Regional health planning under the Health Planning Act has been in effect in Kansas City since 1975 when the Secretary of HEW designated Mid-America Health Systems Agency (MAHSA) as the Health Systems Agency (HSA) for the Kansas City metropolitan area. One of the major functions of the HSA under the Act is to conduct "need reviews" to determine whether new services or facilities planned by health care providers are needed in the regional planning areas. 42 U.S.C. § 3001-2 (f). If not needed, the HSA will not grant a certificate of need to enable the proposed development to proceed.

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6. The Health Planning Act was enacted in 1974. At that time, 47 states, including Missouri, had state approval requirements in effect. Texas and Vermont enacted legislation in 1975, followed by West Virginia and the District of Columbia in 1977. Missouri terminated its Section 1122 Agreement in 1976, so that when petitioner hospital began construction in 1977, Missouri was the *only* state in the Union that did not require prior agency approval before beginning hospital construction. A complete listing of all state programs and their date of enactment is provided in Appendix B to Respondent's Brief.

7. MEDICINE IN THE PUBLIC INTEREST, INC., CERTIFICATE OF NEED: AN EXPANDING REGULATORY CONCEPT 3 (1978).

State legislation, however, is necessary in order to *require* health care providers to first obtain a certificate of need from an HSA before undertaking expansion. In Missouri, although MAHSA had a need review program in operation from 1976 onward, the lack of state enabling legislation between 1976 and 1979 meant that health care providers, including hospitals, were not required to seek MAHSA's approval prior to beginning new development. Petitioner took advantage of this gap in state legislation in order to construct National Gerimedical Hospital without first seeking a certificate of need from MAHSA.

Petitioner overstates its case in arguing that the decision of the Court of Appeals, based upon implied repeal of the antitrust laws, has far-reaching implications for the health care industry. Implied repeal was the sole issue here because of the unique circumstances in which this case arose. By virtue of state legislation currently existing in Missouri and elsewhere, other cases arising under the Act will not be decided on this basis. Instead, the recurring issue will be whether private conduct mandated by state legislation under the Act should be exempt from antitrust laws under the *Parker v. Brown*[8] or the *Noerr-Pennington*[9] doctrine.

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8. 317 U.S. 341 (1943). Legislation enacted by the states which may have an adverse effect on competition is not prohibited by the antitrust laws, nor is the action of private parties in compliance with state legislation. *Exxon Corp. v. Governor of Maryland*, 437 U.S. 117, 133 (1978), *rehearing denied*, 439 U.S. 884 (1978); *Lafayette v. Louisiana Power & Light Company*, 435 U.S. 389 (1978).

9. *Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961), *rehearing denied*, 365 U.S. 875 (1961) and *United Mine Workers v. Pennington*, 381 U.S. 657 (1965). This doctrine "protects attempts to influence governmental units and instrumentalities in order to obtain legislation, redress, or action favorable to particular interests." *Huron Valley Hospital, Inc. v. City of Pontiac*, 466 F. Supp. 1301, 1312 (E.D. Mich. 1979). *See also Lamb Enterprises, Inc. v. Toledo Blade Company*, 461 F.2d 506 (6th Cir.), *cert. denied*, 409 U.S. 1001 (1972).

The decision below was predicated on implied repeal because of a quirk in Missouri state enforcement, which did not exist in other states and which no longer exists in Missouri. The unique facts of this case simply do not rise to a level of national importance, nor do the arguments made in Parts IA, IB and IC of the Petition enable petitioner to create a federal question of national importance.

A. The Decision Below Does Not Displace Competition in the Health Care Industry With Unsupervised Private Action

Petitioner's argument in Part IA of the Petition that the Eighth Circuit decision has displaced competition in the health care sector with unsupervised private action, creating an issue of national importance, contains two fallacies. First, petitioner characterizes the appellate decision as creating a "blanket exemption" to the antitrust laws, a position far removed from the actual holding of the Eighth Circuit.[10] Second, petitioner argues that competition is a basic premise underlying the Health Planning Act, and that the Eighth Circuit decision conflicts with this "premise." This is *not* the case. The urgent need for the Health Planning Act was based in large part upon the *failure* of competition to control skyrocketing health care costs and to efficiently allocate resources. As recognized in the Congressional Committee Report on the 1974 Act:

> The need for strengthened and coordinated planning for personal health services is growing more apparent each day. In the view of the Committee *the health care industry does not respond to classic marketplace*

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10. See Part I of Respondent's Brief, *supra*.

forces. The highly technical nature of medical service together with the growth of third party reimbursement mechanisms act to attenuate the usual forces influencing the behavior of consumers with respect to personal health services. (Emphasis added). S. Rep. No. 93-1285, 93d Cong., 2d Sess., 1974 U.S. Code Cong. & Ad. News 7842, at 7878.

The 1979 amendments to the Health Planning Act, rather than indicating Congress' intent to enhance competition in all areas of health care service, actually demonstrate Congress' increased recognition that competition is ineffective in many areas, notably with respect to inpatient health services, such as those involved in this case. Section 1502(b) of the Health Planning Act now states:

> (1) *The Congress finds that the effect of competition on decisions of providers respecting the supply of health services and facilities is diminished.* The primary source of the lessening of such effect is the prevailing methods of paying for health services by public and private health insurers, particularly for inpatient health services and other institutional health services. As a result, there is duplication and excess supply of certain health services and facilities, particularly in the case of inpatient health services.
>
> (2) *For health services, such as inpatient health services and other institutional health services, for which competition does not or will not appropriately allocate supply* consistent with health systems agencies and State health plans, health systems agencies and State health planning and development *agencies should* in the exercise of their functions under this title *take actions* (where appropriate to advance the purposes of quality assur-

> ance, cost effectiveness, and access and the other purposes of this title) *to allocate the supply of such services.* (Emphasis added).

If competition has been "displaced" in the health care sector, it is Congress who has done so and not the Eighth Circuit.

Petitioner further mischaracterizes the holding of the Court of Appeals. The decision below does not substitute "unsupervised private action" for competition. The Court merely recognizes that conduct of private parties in compliance with federal legislation does not violate the antitrust laws. The key to the Eighth Circuit's reasoning is not "private action," but rather the intent of Congress. The Court properly concluded that Congress intended voluntary compliance by private parties in order to implement the Health Planning Act. (628 F.2d at 1056-1057; App. A at 12a-16a). That such compliance could violate the antitrust laws would yield a patently absurd result, so the Court of Appeals held that repeal of the antitrust laws for specific conduct in compliance with the Act must be implied. Petitioner's quantum leap in arguing that this decision eliminates competition in the health care industry is unjustified.

The decision below neither displaces competition in the health care industry nor substitutes private action for competition. This case does not present an issue of national importance warranting review by this Court.

B. Review of the Decision Below Will Not Clarify the General Ground Rules Governing Antitrust Liability in the Health Care Industry

The contention of petitioner in Part IB of the Petition that review of the decision below is required to clarify the scope of antitrust liability in the health care industry

is unsupported and incorrect. The facts of this case, which necessitated that the Eighth Circuit decision be based only on implied repeal, are unique. A decision by this Court on implied repeal, the sole legal question here presented, will provide no guidance to lower courts on the principal theory of other cases which may arise under the Act—the "state action" exemption to the antitrust laws.

The cases cited by petitioner illustrate this. *Huron Valley Hospital, Inc. v. City of Pontiac,* 466 F. Supp. 1301 (E.D. Mich. 1979), was decided specifically on "state action" grounds. Implied repeal of the antitrust laws was mentioned as an argument raised by defendant, but was *not* the basis for the district court's decision. Furthermore, in the absence of a ruling by the Sixth Circuit, it is mere conjecture by petitioner to suppose that implied repeal will be the basis of the appellate opinion in that case.

No opinion has even been announced in *North Carolina v. P.I.A. Asheville, Inc.* (Civ. No. A-C-80-29), where the district court has stayed all proceedings pending state agency determination. The legal theories that will eventually be adopted by the district court are a matter of speculation, but in light of the district court's deference to the state agency, it is likely that a decision in defendant's favor would be based upon a "state action" exemption.

This is simply not an appropriate case in which to define the scope of antitrust liability under the Health Planning Act. This case presents only the issue of implied repeal. That issue existed solely because of the gap in Missouri enforcement legislation, which has since been eliminated. Implied repeal alone is unlikely to be the basis for future decisions. The relationship of the "state action" exemption to the Health Planning Act may be

an issue to be resolved under the Act, but it is not presented by this case. A review of the present case necessarily would be limited in its scope and usefulness to the unique facts of this case, and would not provide guidance to lower courts on the very different antitrust issues confronting them under the Health Planning Act.

Petitioner attempts to create an additional problem by stating that the Department of Justice has adopted a position different from the decision below. This is untrue. The Eighth Circuit decision did not grant a "blanket exemption" for the health care industry, and the decision below is not inconsistent with the Department of Justice statement. Petitioner's effort to put the Eighth Circuit's comprehensive opinion on the same footing with a Department of Justice Business Review Clearance is clearly unwarranted. The same record has not been developed in the Justice Department determinations. The same principles are not involved. The factual situations are different and different standards apply. The two cannot be validly compared.

Similarly, petitioner's effort to raise additional questions by claiming that "appropriateness review" and Professional Standards Review Organization legislation are threatened by the Court of Appeals' decision are without basis and constitute an attempt to create antitrust problems where none currently exist. This case presents a narrow set of facts and a correspondingly narrow decision. Broad questions of antitrust liability are not involved here and cannot be created by petitioner so as to justify this Court's review.

C. The Decision Below Does Not Impair Other Decisions of This Court With Respect to the Health Care Industry

To argue, as petitioner does in Part IC of the Petition, that this decision will impair other decisions of this Court based on different facts and law is to seriously overstate the scope and effect of the Eighth Circuit's holding. Even a cursory reading of that opinion suffices to demonstrate that no questions involving "learned professions," the "state action" exemption, or interstate commerce were presented to or decided by the Eighth Circuit. Nothing in the Eighth Circuit opinion affects in any way those issues.

Petitioner states that "[t]he decision below would effectively undo this Court's decision in [*Hospital Building Company v. Trustees of*] *Rex Hospital,* [425 U.S. 738 (1976)]." (Petition at 14). *Rex Hospital* dealt solely with the scope of interstate commerce. The Court recognized, in its limited holding that the complaint should not have been dismissed for failure to state a claim:

> It may, of course, be that even though petitioner's complaint adequately alleges an effect on interstate commerce, further proceedings in this case will demonstrate that respondents' conduct in fact involves no violation of law, or indeed no substantial effect on interstate commerce. 425 U.S. at 747 n.5

The *Rex Hospital* opinion is in no way a decision on the merits. The Court anticipated that other issues might arise which would bar recovery by plaintiffs. The Eighth Circuit decision in the present case clearly does not conflict with this Court's decision in *Rex Hospital.*

Even more clearly, nothing in the decision below limits this Court's holding in *Group Life & Health Insurance Company v. Royal Drug Company,* 440 U.S. 205 (1979),

rehearing denied, 441 U.S. 917 (1979). Both the appellate and trial courts concluded that the *Royal Drug* opinion definitively controlled this case, and held that respondents were not entitled to an exemption under the McCarran-Ferguson Act. (628 F.2d at 1057; App. A at 15a; 479 F. Supp. at 1019). Petitioner's contention to the contrary is completely unfounded.

In summary, the decision below does not impinge upon or limit this Court's prior rulings. Other cases were decided upon dissimilar facts, dissimilar statutes and dissimilar legal theories. The unique facts of this case and the narrow ruling by the Eighth Circuit do not affect other decisions by this or any other court with respect to the health care industry.

III.

The Decision Below Properly Applies Settled Principles of Implied Repeal in a Narrow Factual Context and Is Fully Consistent With Prior Decisions of This Court

Petitioner presents specious reasoning to conclude that the decision below conflicts with applicable decisions of this Court. Petitioner first posits that the holding of the Eighth Circuit creates a "blanket exemption" from the antitrust laws under the Health Planning Act, and petitioner then explains reasons why creation of a "blanket exemption" conflicts with prior decisions of this Court. The obvious flaw in this argument is its erroneous premise. The decision below clearly does *not* hold that the Health Planning Act constitutes a "blanket exemption" from antitrust liability as petitioner suggests. Quite the contrary, the Court of Appeals' decision necessarily is strictly circumscribed by the narrow factual context presented, and its holding recognizes an implied repeal *only* with respect

to the *specific conduct* alleged under the *peculiar circumstances* in which it occurred.[11] Petitioner's theory that the opinion conflicts with prior decisions of this Court is totally without merit. Review by this Court on that ground is wholly unwarranted.

A. The Decision Below Does Not Conflict With Decisions of This Court by Extending the Doctrine of Implied Repeal to Statutes Involving No Federal Regulatory Scheme

Petitioner contends in Part IIA of the Petition that certiorari should be granted because the Court of Appeals' decision "extends the doctrine of implied repeal to statutes involving no federal regulatory scheme whatever." (Petition at 20). To the extent this contention is based on the unfounded presumption that the decision below creates a "blanket exemption" from antitrust liability, it is plainly without merit for the reasons previously stated. And to the extent petitioner also suggests that the decision below conflicts with applicable decisions of this Court by otherwise improperly extending the doctrine of implied repeal, that suggestion is equally without merit for at least two reasons.

First, the decision below is totally consistent with and follows prior decisions of this Court because the Court below expressly found that the Health Planning Act *does* enact a federal regulatory scheme. In the course of analyzing the implied repeal issue, the Court of Appeals stated:

> Missouri's lack of state participation did not affect the Act *which set up a regulatory scheme* which designated MAHSA as a regulatory need review agency. More specifically, it has no effect upon that portion

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11. See Part I of Respondent's Brief, *supra*.

> of the legislation *which calls for a regulatory system* which included the designated HSA implementing the HSP and the AIP with the assistance of individuals and public and private entities in its health service area. (Emphasis added). 628 F.2d at 1055; App. A at 10a.

The Court then proceeded to describe in detail "[t]he extent of this regulatory scheme" by referring to the findings of the District Court in that regard. (628 F.2d at 1055; App. A at 10a). The decision below clearly is not inconsistent with decisions of this Court applying the implied repeal doctrine in the context of a federal regulatory scheme.

Second, petitioner's suggestion that, under this Court's decisions, a "pervasive federal regulatory scheme" is an absolute condition precedent to finding a conflict with the antitrust laws justifying implied immunity, is incorrect. This Court has directly stated that a pervasive regulatory scheme is *not* an essential ingredient of the implied repeal doctrine in *Gordon v. New York Stock Exchange, Inc.*, 422 U.S. 659 (1975). In *Gordon*, this Court rejected precisely the argument petitioner makes here when the Court stated:

> The United States appears to suggest that only if there is a pervasive regulatory scheme, as in the public utility area, can it be concluded that the regulatory scheme ousts the antitrust laws. . . . It is true that in some prior cases we have been concerned with the question of the pervasiveness of the regulatory scheme as a factor in determining whether there is an implied repeal of the antitrust laws. . . . In the present case, however, respondents do not claim that repeal should be implied because of a pervasive regulatory scheme, but because of the specific provision of §19(b)(9) and

> the regulatory action thereunder. . . . Hence, whether the Exchange Act amounts to pervasive legislation ousting the antitrust acts is not a question before us. 422 U.S. at 688-689.

Under *Gordon,* petitioner's argument that the opinion below conflicts with decisions of this Court for lack of a required "pervasive federal regulatory scheme" necessarily fails.

Petitioner's imagined fear that absent review the decision below will breed uncertainty and confusion among lower courts regarding the scope of the implied immunity doctrine and the relationship of that doctrine to the "state action" exemption, is equally unfounded. To date three separate courts have examined the Health Planning Act and its legislative history, and each has concluded that Congress intended immunity from antitrust liability for actions taken pursuant to the Act.[12] This can hardly be described as uncertainty or confusion among the lower courts.

The only "uncertainty and confusion" pointed to by petitioner is a claimed conflict in the Eighth Circuit by virtue of the decision in *Sound, Inc. v. American Telephone & Telegraph Company,* No. 80-1047 (8th Cir., August 25, 1980). The *Sound, Inc.* decision further clarifies, rather than confuses, the scope of the implied immunity doc-

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12. In the first decision, the district court in the Eastern District of Michigan found that the legislative history of the Act demonstrated Congress' intent to partially repeal the antitrust laws. *Huron Valley Hospital, Inc. v. City of Pontiac,* 466 F. Supp. 1301, 1305 (E.D. Mich. 1979). In the second decision, the district court in the Western District of Missouri in this case discussed this issue at length and reached the same conclusion. 479 F. Supp. at 1019-1023. Finally, the panel of the Eighth Circuit in this case unanimously found likewise in the decision below. (628 F.2d 1054-1057; App. A at 8a-16a).

trine.[13] In any event, an intra-circuit conflict alone does not justify granting certiorari. *Davis v. United States*, 417 U.S. 333, 340 (1974).

With regard to the "state action" exemption, it is petitioner's argument here, not the decision below, which confuses this issue. The "state action" exemption from antitrust liability is not involved under the facts of this case, and the Court below expressly and accurately so ruled. (628 F.2d at 1054; App. A at 9a-10a). Therefore, this case is *not* an appropriate one in which to clarify the relation between these two doctrines,[14] and accordingly, certiorari is not proper to review that question in this case. *Kimbrough v. United States*, 364 U.S. 661 (1961) (writ of certiorari dismissed as improvidently granted where under the facts the question presented for review was "not presented with sufficient clarity in this case").

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13. In *Sound, Inc., supra*, the Eighth Circuit considered questions of antitrust liability in the context of the Communications Act of 1934. The Court treated separately and at great length both implied immunity and the state action exemption. The Court concluded that the conduct there at issue was not beyond reach of the antitrust laws under either theory.

14. During the relevant period in this case Missouri had no Certificate of Need legislation. Missouri later enacted such legislation, and currently virtually every other state in the Union has done so as well. Therefore, it is highly unlikely that the specific issue decided in this case—the question of implied immunity under the Health Planning Act wholly apart from any state action issue—will ever arise again. See Part II of Respondent's Brief, *supra*. In any event, there are cases pending in lower courts which present the implied immunity vis-a-vis state action exemption issue petitioner urges this Court to decide in this case. *See, e.g., Huron Valley Hospital, Inc. v. City of Pontiac*, 466 F. Supp. 1301 (E.D. Mich. 1979). This case should not be utilized to decide that issue, if further decision be needed.

B. The Decision Below Does Not Conflict With Decisions of This Court by Extending the Doctrine of Implied Repeal to Private Voluntary Conduct Subject to No Governmental Oversight

Petitioner's "governmental oversight" argument in Part IIB of the Petition reflects a fundamental misconception of the true basis for invoking the implied immunity doctrine. The doctrine is *not* founded on the presence of "oversight" by a regulatory agency, as petitioner suggests. The true basis for the doctrine is the *intent of Congress* to exempt the conduct involved from the antitrust laws. Regulatory oversight is but one possible indication of such intent.[15] This Court's decisions make it quite clear that the single, most fundamental premise of the implied repeal doctrine is congressional intention to afford such immunity. *United States v. National Association of Securities Dealers, Inc.*, 422 U.S. 694, 720-722, 726-727 (1975); *Gordon v. New York Stock Exchange, Inc.*, 422 U.S. 659, 663-667, 686, 690-691 (1975); *Federal Maritime Commission v. Seatrain Lines, Inc.*, 411 U.S. 726, 729, 736-743 (1973); *Ricci v. Chicago Mercantile Exchange*, 409 U.S. 289, 302-303 (1973); *United States v. Philadelphia National Bank*, 374 U.S. 321, 350-352 (1963); *Silver v. New York Stock Exchange*, 373 U.S. 341, 364 (1963), *rehearing denied*, 375 U.S. 870 (1963); *Pan American World Airways, Inc. v. United States*, 371 U.S. 296, 304-305, 311-312 (1963); *United States v. Borden Company*, 308 U.S. 188, 198-199, 204 (1939).

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15. *See, e.g., MCI Communications Corporation v. American Telephone & Telegraph Company*, 462 F. Supp. 1072, 1083 (N.D. Ill. 1978), *aff'd*, 594 F.2d 594 (7th Cir. 1978), *cert. denied*, 440 U.S. 971 (1979); *Oahu Gas Service, Inc. v. Pacific Resources, Inc.*, 460 F. Supp. 1359, 1372 (D. Hawaii 1978).

In finding an implied repeal in this case, the Eighth Circuit focused on congressional intent by examining both the language of the Health Planning Act itself and its legislative history. Based on that analysis the Court below found that it was indeed the intent of Congress to afford an exemption from antitrust liability for the particular conduct in question. (628 F.2d at 1054-1057; App. A at 8a-16a). The decision below is in direct accord with the decisions of this Court in applying the doctrine of implied repeal.

It is difficult to meaningfully distinguish between petitioner's arguments based on "no governmental oversight" and "no federal regulatory scheme." As already discussed, the Court below specifically found that the Health Planning Act does in fact create a federal regulatory scheme governing the conduct involved in this case, and that would also appear to dispel petitioner's imagined conclusion that this case involves "no governmental oversight whatever."[16]

C. The Decision Below Properly Follows and Applies the Principles Governing Implied Repeal Established by This Court

Petitioner argues, in Part IIC of the Petition, that the decision below conflicts with principles governing implied repeal established by this Court because "blanket

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16. Petitioner greatly exaggerates the circumstances in this case by describing respondent's actions as "private voluntary conduct subject to no governmental oversight whatever." This misstates the facts. Respondent's conduct cannot fairly be characterized as purely voluntary, as it was found to be expressly authorized and intended under directives of the Health Planning Act—the action was taken pursuant to a Health Systems Plan developed by MAHSA as required under the Act and the action was deemed necessary by MAHSA to assist in implementation of the Plan, all as directed and contemplated under the Act. Furthermore, the combination or conspiracy alleged by petitioner presumably included as a participant MAHSA, which was a quasi-public agency during the relevant period and is a fully state-sanctioned public agency now.

exemptions have been uniformly disapproved by this Court." (Petition at 24). Again, this argument disregards the narrow factual context involved in this case and the limited scope of the actual holding of the Eighth Circuit.

The Court of Appeals fully recognized and followed the principle that implied immunity from antitrust liability should be narrowly limited to that required to make the regulatory scheme work. The Court directly noted at the outset of its analysis that "the doctrine of implied immunity is to be used sparingly and only when necessary" (628 F.2d at 1054; App. A at 8a), and the Court later reiterated that "implied immunity can be found in 'particular and discrete instances' . . .", quoting from *United States v. National Association of Securities Dealers, Inc.*, 422 U.S. 694, 734 (1975). (628 F.2d at 1055; App. A at 11a). The Court found a "clear repugnancy" between the Health Planning Act and the antitrust laws as regards the particular conduct at issue (628 F.2d at 1055-1056; App. A at 12a), and also found based on the legislative history of the Act that Congress intended such conduct to be exempt from antitrust liability (628 F.2d at 1056-1057; App. A. at 12a-16a), all as required under this Court's applicable decisions. *United States v. National Association of Securities Dealers, Inc.*, 422 U.S. 694, 721-722 (1975); *Gordon v. New York Stock Exchange, Inc.*, 422 U.S. 659, 682, 691 (1975); *Federal Maritime Commission v. Seatrain Lines, Inc.*, 411 U.S. 726, 729, 733 (1973); *United States v. Philadelphia National Bank*, 374 U.S. 321, 350-352 (1963); *Pan American World Airways, Inc. v. United States*, 371 U.S. 296, 304-305, 311-312 (1963); *United States v. Borden Company*, 308 U.S. 188, 198-199 (1939).

Thus, petitioner's characterization that the Court below "went out of its way to find a conflict in direct contravention of the precedents of this Court," (Petition at 24), inaccurately and unfairly describes the analysis by the Court below. In reality, the Court of Appeals

followed and properly applied the settled principles of implied repeal within the unique factual context presented. Where, as here, any asserted conflict in decisions only arises from differences in the facts, and not in application of principles of law, review by certiorari is not warranted. *Sanchez v. Borras,* 283 U.S. 798, 798-799 (1931); *Wisconsin Electric Company v. Dumore Company,* 282 U.S. 813 (1930).

Petitioner's final argument is that the decision below does not follow the rule of statutory interpretation that the specific statement of an exemption is the exclusion of any others, and thereby conflicts with decisions of this Court ruling that antitrust immunity should not be implied beyond any express statutory exemption. This argument fails because it overlooks the reason for the rule, which is to determine the *intent of Congress* in enacting the statute in question. The rule has no application where the intent of Congress is otherwise evident. Indeed, in the very case cited by petitioner to invoke that "basic rule of statutory interpretation," *National Railroad Passenger Corporation v. National Association of Railroad Passengers,* 414 U.S. 453 (1974), *rehearing denied,* 415 U.S. 952 (1974), this Court after noting the "rule" went on to state:

> But even the most basic general principles of statutory construction must yield to clear contrary evidence of legislative intent. 414 U.S. at 458.

In this case, contrary to the four cases referred to in the Petition,[17] the legislative history of the Health Plan-

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17. *Federal Maritime Commission v. Seatrain Lines, Inc.,* 421 U.S. at 733; *California v. Federal Power Commission,* 369 U.S. at 483; *Carnation Company v. Pacific Westbound Conference,* 383 U.S. at 216-217; *United States v. Borden Company,* 308 U.S. at 201. (Petition at 25). In none of those cases was there any finding, as there is in this case, that the legislative histories of the statutes involved clearly demonstrated congressional intention to immunize the conduct involved from antitrust liability.

ning Act, considered together with the specific provisions of the Act itself, clearly reflect Congress' intent to exempt from the antitrust laws the particular conduct involved here. The Court below found an implied repeal only after examining the legislative history of the Act "in order to determine the congressional intent in regard to immunity." (628 F.2d at 1056; App. A at 12a). Therefore, the decision below does not conflict with prior decisions of this Court applying the rule of statutory construction relied on by petitioner. In fact, this Court has recognized that antitrust immunity *can* be implied *despite* a grant of express immunity which does not cover the conduct charged. *United States v. National Association of Securities Dealers, Inc.*, 422 U.S. 694, 720 (1975) (antitrust immunity implied under § 22(f) of the Investment Company Act of 1940 despite the inapplicability of the express immunity granted under § 22(d) of the Act); *Pan American World Airways, Inc. v. United States*, 371 U.S. 296, 304-310 (1963) (implied antitrust immunity held applicable to actions which were beyond the express immunity provision of § 414 of the Federal Aviation Act). *See also Hughes Tool Company v. Trans World Airlines, Inc.*, 409 U.S. 363, 385-386 (1973), *rehearing denied*, 410 U.S. 975 (1973).

The decision below does not conflict with any of the principles governing implied repeal established by applicable decisions of this Court and, accordingly, the instant petition should be denied on that ground.

CONCLUSION

For the above reasons, Respondent Blue Cross of Kansas City respectfully requests that the Petition for Writ of Certiorari be denied.

Respectfully submitted,

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APPENDIX

APPENDIX A

Opinion of the Eighth Circuit Court of Appeals

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 79-2018

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER,
Appellant,

v.

BLUE CROSS OF KANSAS CITY, BLUE CROSS ASSOCIATION,
Appellees.

(Filed July 22, 1980)

Before STEPHENSON and MCMILLIAN, Circuit Judges, and SACHS, *District Judge.

STEPHENSON, Circuit Judge

The National Gerimedical Hospital, plaintiff-appellant, appeals from a summary judgment granted to defendant-appellee Blue Cross of Kansas City. National had charged Blue Cross and others[1] with violations of sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2. The trial court[2] found Blue Cross' activities to be taken pursuant

*The Honorable Howard F. Sachs, United States District Judge for the Western District of Missouri, sitting by designation.

1. Blue Cross of Kansas City and Blue Cross Association were named defendant coconspirators. There were several non-defendant coconspirators listed in the plaintiff's complaint, including Mid-America Health Systems Agency, Inc. (MAHSA).

2. The Honorable Russell G. Clark, United States District Judge for the Western District of Missouri.

to Public Law 93-641, the National Health Care Planning and Resources Development Act of 1974, 42 U.S.C. § 300k, *et seq.*; that there was a repugnancy between the Act and the antitrust laws; and that consequently, under the doctrine of implied immunity, Blue Cross' activities were immune from the antitrust laws. *National Gerimedical Hospital & Gerontology Center v. Blue Cross,* 479 F. Supp. 1012 (W.D. Mo. 1979). We affirm the district court.

I. Statutory Background

The related health care statutes, as they existed during the relevant time period, are as follows.

Prior to the National Health Care Planning and Resources Development Act of 1974, the Public Health Service Act, 42 U.S.C. § 291, *et seq.* (known as the Hill-Burton Act) was the primary legislation channeling federal funds to states in support of construction and modernization of health care facilities. The Hill-Burton Act provides, as does much federal legislation involving state cooperation, for voluntary participation by the states. The participating state submits a state plan to HEW, which designates a particular state agency to be in charge of administering the state program and determining, *inter alia,* the need for new or expanded health care facilities. While an applicant could build without approval by the state agency, such applicant would not be eligible for reimbursement by the federal government. *Lakeside Mercy Hospital, Inc. v. Indiana State Board of Health,* 421 F. Supp. 193, 196-97 (N.D. Ind. 1976).

Other prior legislation providing for channeling federal funds into health care programs includes the Public Health Service Act § 314, 42 U.S.C. § 246 (amended 1978 and 1979). Under this program, federal funds are channeled to participating states that submit, and have approved

by HEW, a Comprehensive Health Planning State Plan. This legislation provides for a state agency to be designated to screen health care applications in order to verify the need for new facilities and programs under the approved state plan, and also, in cooperation with the state agency, the Act provides for Area Comprehensive Health Planning Agencies. *Id.* at 197.

Section 1122 of the Social Security Act, 42 U.S.C. § 1320a-1 (amended 1978 and 1979), enacted in 1972, provides for a participating state program for repayment provisions for Medicaid and Medicare, for which repayment prior to that time had not been dependent upon need approval by any of the various state health agencies (those designated by the state pursuant to compliance with federal requirements in order to be a participating state). Section 1122 of the Social Security Act authorizes HEW to enter into agreements with participating states whereby a state agency is designated as a health planning agency. This agency develops a state plan and makes recommendations as to the need of proposed expenditures for health care facilities, in conformity with regulations promulgated by HEW. Once final approval by HEW is received, the capital expenditure qualifies for purposes of reimbursement, via Medicaid and Medicare payments, the portion of fees allocable to return of depreciation, debt service and other capital related expenditures. *Id.*

The purpose of the National Health Care Planning and Resources Development Act of 1974, also providing for a participating state program, is "to facilitate the development of recommendations for a national health planning policy, to augment areawide and State planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy." 42 U.S.C. § 300k(b).

Part B of the Act, 42 U.S.C. § 3001, provides for the establishment of health service areas and corresponding health systems agencies (HSAs). The purposes of the HSAs as stated in the Act include, *inter alia,* "preventing unnecessary duplication of health resources." 42 U.S.C. § 300*l*-2(a). In order to accomplish its purposes, the HSA is to establish a health systems plan (HSP) and an annual implementation plan (AIP) which will achieve the goals of the HSP. 42 U.S.C. § 300*l*-2(b)(2). The Act specifically provides that the HSA shall implement the HSP and AIP, and "*shall* seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entitites in its health service area." 42 U.S.C. § 300*l*-2(c)(1) (emphasis added). It is this section of the Act upon which the district court primarily rests its finding of antitrust immunity for the actions of Blue Cross.

II. Facts

Construction of the National Gerimedical Hospital began in August 1976 and was completed in September 1978. On October 4, 1977, Hospital submitted to Blue Cross a request for a member hospital contract. Pursuant to such contracts Blue Cross reimburses individual members the cost of all covered health services received at member hospitals. If health services are received by individual members at nonmember hospitals, Blue Cross individual members receive only up to eighty percent of the cost of the covered medical services. Also, for health services received at member hospitals, Blue Cross reimburses or pays the hospital for the services provided its individual members; with a nonmember hospital, the reimbursement is paid to the individual member, not to the hospital.

Blue Cross advised Hospital that Hospital must first secure need approval of Mid-America Health Services

Agency (MAHSA) in order to be eligible for favorable consideration by Blue Cross for a member hospital contract.

MAHSA, named as a non-defendant alleged coconspirator,[3] is a private not-for-profit Missouri corporation engaged in voluntary health planning. MAHSA was conditionally designated an HSA under the Act and was notified of its designation for the eight county bi-state region of the metropolitan Kansas City area by letter from HEW on April 7, 1976. *Mid-America Regional Council v. Mathews*, 416 F. Supp. 896, 899 (W.D. Mo. 1976). Thus during the relevant time period of this case, MAHSA enjoyed this status.

Prior to this time period, Missouri had participated in the Social Security Act § 1122 Capital Health Care Expenditures Program, which included a State Planning Agency that performed section 1122 program reviews, as discussed *infra*, 42 U.S.C. § 1320a-1 (amended 1978 and 1979). Blue Cross had required that large capital expenditures be approved by the local and regional planning arm of the section 1122 State Planning Agency before, *i.e.*, a hospital could be a member institute. This Capital Expenditure Program, as discussed *infra*, was designed to assure that federal funds appropriated for Medicaid and Medicare were not used to support unnecessary capital expenditures for health care facilities.

Area agencies established under 42 U.S.C. § 246 (amended 1978 and 1979), discussed *infra*, Area Comprehensive Health Planning Agencies (CHPs), were used in conjunction with the need approvals necessary under 42 U.S.C. § 1320a-1 (amended 1978 and 1979). The applicant for Medicaid and Medicare cost reimbursement had to seek a favorable recommendation from the CHP and

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3. *See* note 1 *supra*.

secure a favorable determination of need from the state planning agency, the Missouri State Health Planning and Development Agency. The CHP for Missouri was MAHSA. The National Health Planning and Resources Development Act of 1974 gives preference to § 246 area agencies, CHPs and existing regional planning areas. 42 U.S.C. § 300*l*-4(b)(4) and § 300*l*(a)4.

On June 30, 1976, Missouri, a participating state under 42 U.S.C. § 1320a-1 (amended 1978 and 1979) since 1973 refused to renew Missouri's contract with HEW and Missouri's Program for Capital Health Care Expenditures was terminated.

On July 21, 1976, as reflected by a "Special Newsletter" to Blue Cross member hospitals in Missouri, Blue Cross gave notice that all projects in the Kansas City metropolitan area not reviewed and approved by MAHSA would not be reimbursible by Blue Cross of Kansas City.

> Blue Cross of Kansas City has been observing with considerable interest the events regarding the State of Missouri's cancellation of the SSA-1122 Capital Expentiture Program. It appears at this time that the final position of the Department of Health, Education, and Welfare on this matter has not been clarified with respect to reimbursement sanctions.[4] It also appears that the State of Missouri has no intention of reinstating the State Comprehensive Health Planning Agency to perform the SSA-1122 program review.
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> In view of this action, the Provider Relations Committee of the Blue Cross Board of Trustees felt it necessary to advise all Missouri Member Hospitals

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4. Appellant advises us that no question has been raised concerning Hospital's entitlement to full Medicare reimbursement.

of our position on this matter. As you are aware, the Member Hospital Contract contains a provision that capital expenditures of over $350,000 or 5% of the hospital's operating expense in the most recent fiscal year, whichever is lesser, be approved by the local or regional planning agency. Since the State Planning Agency no longer exists, Blue Cross of Kansas City will look to the local Health Systems Agency for approval of such capital projects. That Health Systems Agency in the Kansas City metropolitan area is the Mid-America Health Systems Agency and in the balance of our operating area, Area II Health Systems Agency. *All projects not reviewed and approved by these Health Systems Agencies will not be reimbursible by Blue Cross of Kansas City.*

Therefore, we urge you to continue working with these agencies and Blue Cross of Kansas City in future planning needs for your hospital. Should you have any questions regarding our position on this matter, please do not hesitate to consult with us.

MAHSA was, of course, designated as the HSA under the Act. However, Missouri, during the relevant time period, had no law implementing the Act in Missouri nor designating any state agency thereunder in accordance with 42 U.S.C. § 300m.

MAHSA had publicly stated that it would disapprove and not consider favorably the addition of any acute care hospital beds; acute care hospital beds are the type Hospital provided; Hospital did not submit an application for need review to MAHSA; Hospital's application for a member contract with Blue Cross was denied in March 1978 by Blue Cross because Hospital had not received approval through the voluntary health planning process as required by the Special Newsletter. Hospital then filed this lawsuit.

III. Analysis

National argues that by requiring National to get need approval from MAHSA before it applies for a member hospital contract with Blue Cross, Blue Cross violates the antitrust laws. National contends that the requirement constitutes a contract, combination or conspiracy in restraint of trade, Sherman Act § 1, 15 U.S.C. § 1, and an abuse of Blue Cross' monopoly power in the private health care reimbursement plan market, Sherman Act § 2, 15 U.S.C. § 2.

What defeats National's otherwise appealing argument are the specific provisions of the National Health Planning and Resources Development Act for voluntary cooperation and assistance of private entities and persons in the community and health care market. While the doctrine of implied immunity is to be used sparingly and only when necessary, *Gordon v. New York Stock Exchange, Inc.*, 422 U.S. 659 (1975), these provisions make the instant situation one well-suited for its use.

The necessity of application of the doctrine of implied immunity arises if there is (1) a clear repugnancy between the antitrust laws and the specific conduct at issue and (2) if the intent of Congress is that implied repeal of the antitrust laws was intended. *Essential Communication Systems, Inc. v. AT&T*, 446 F. Supp. 1090, 1094-95 (D.N.J. 1978).

As to the first prerequisite, the district court herein stated its finding of repugnancy best when it stated:

> If the Court were to find that private business working in conjunction with the health systems agency established by the Act in their area to achieve the goals of the Act were liable or might be liable under

> the antitrust laws for their action, then * * * the accomplishment of the purpose of the goals of the Act would be effectively foreclosed.

National Gerimedical Hospital & Gerontology Center v. Blue Cross, supra, 479 F. Supp. 1012, 1021 (W.D. Mo. 1979).

National's emphasis upon the fact that Missouri was not a participating state—"at all times here pertinent, Missouri had no law implementing P.L. 93-641 in Missouri nor designating any state agency thereunder in accordance with 42 U.S.C. § 300m" (brief for appellant at 12-13)—misses the focus of the doctrine of implied immunity. The doctrine should not be confused with the state action exemption to the antitrust laws as articulated in *Parker v. Brown,* 317 U.S. 341 (1943). The doctrine of implied immunity, in fact,

> is actually a subspecie of implied statutory repeal. *See, Gordon v. N.Y. Stock Exchange,* 422 U.S. 659, 682, 95 S.Ct. 2598, 45 L.Ed.2d 463 (1975), and *U. S. v. Southern Motor Carriers Rate Conference,* 439 F. Supp. 29, 35 (N.D. Georgia, 1977). It is one of several distinct judicially created rules, which include "primary jurisdiction" and "exhaustion of administrative remedies", designed to resolve potential conflicts between two regimes with federal statutory authorization to regulate the conduct of business entities: federal administrative agencies and federal courts enforcing (among others) the antitrust laws.
>
> The antitrust laws posit that the public interest is best served when business enterprises are compelled to compete in markets free of anti-competitive restraints. In contrast, the basic premise of administrative regulation is that the freedom of business en-

> tities must be in some degree curtailed to maximize the general welfare. When the same conduct falls within the scope of both the antitrust laws and a regulatory scheme, potential conflicts of competency and policy are resolved under the doctrine of implied immunity.

Essential Communication Systems, Inc. v. AT&T, supra, 446 F. Supp. at 1094 (footnote omitted). Missouri's lack of state participation did not affect the Act which set up a regulatory scheme which designated MAHSA as a regulatory need review agency. More specifically, it has no effect upon that portion of the legislation which calls for a regulatory system which included the designated HSA implementing the HSP and AIP "with the assistance of individuals and public and private entities in its health service versa." 42 U.S.C. § 300*l*-2(c)(1).

The extent of this regulatory scheme is demonstrated by the district court's discussion.

> Mid-America Health Systems Agency was one of 205 regional health systems agencies established under the Act * * *. In November of 1977 Mid-America Health Systems established a health systems plan for 1978 through 1982 in this region. Increasing hospital costs and unnecessary duplication of facilities and equipment were considered two of the biggest problems in this region. The health systems plan adopted by Mid-America Health Systems recognized:
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> Problem—The acute inpatient care system does not function in a coordinated manner which is cost-effective in the delivery of acute care services at the most appropriate level consistent with quality standards. (Health Systems Plan at pp. 6-19.)

The goal in this area was recognized as:

> Goal: Improve the health of the population in the MAHSA area through an adequately available and accessible acute inpatient care system coordinated in a manner that fosters containment of health care costs and provides quality of care in a culturally acceptable manner. (Health Systems Plan at pp. 6-19.)

To implement this goal MAHSA established a number of objectives in this area and specified particular methods that could be utilized to achieve each objective. Objective No. 4 seeks to:

> Objective #4
>
> Maintain a rate of increase in total expenditures for hospital care services which does not exceed the rate of increase in the medical care services component of the Consumer Price Index. (Health Systems Plan at pp. 6-21.)

As one of the nine methods set forth to meet this goal, Mid-America Health System suggested:

> (6) Third party payors and the hospital community should work together to develop uniform reporting systems and procedures such that meaningful hospital-to-hospital and year-to-year hospital cost and service-by-service utilization comparisons can be made. (Health Systems Plan at pp. 6-22.)

National Gerimedical Hospital & Gerontology Center v. Blue Cross, supra, 479 F. Supp. at 1020-21. Implied immunity can be found in "particular and discrete instances to assure that the federal agency entrusted with regulation in the public interest could carry out that responsibility free from the disruption of conflicting judgments that might be voiced by courts exercising jurisdiction under

the antitrust laws." *United States v. National Association of Securities Dealers, Inc.*, 422 U.S. 694, 734 (1975).

We agree with the district court's finding of clear repugnancy between the Act and the antitrust laws, as the Act and regulatory scheme clearly call for the action which has now become the basis of an antitrust claim.

We now examine the history of the Act in order to determine the congressional intent in regard to immunity. The district court concluded, after a thorough review of the legislative history, that it was the intent of Congress to immunize this type of voluntary action from the antitrust laws. We cannot improve on the district court's discussion:

> In essence the antitrust laws posit that the public interest will be served best when business enterprises are compelled to compete in markets free of anti-competitive restraints. * * * The concern of the Senate Committee that considered the health care legislation at issue here was the failure of the health care industry to "respond to classic marketplace forces." See Volume 4, U.S. Code Cong. & Admin. News at p. 7878, U.S. Code Cong. & Admin. News 1974, p. 7878. In the Committee's view:
>
> > The highly technical nature of medical services together with the growth of third party reimbursement mechanisms act to attenuate the usual forces influencing the behavior of consumers with respect to personal health services. For the most part, the doctor makes purchasing decisions on behalf of the patient and the services are frequently reimbursed under health insurance programs, thus reducing the patient's immediate incentive to contain expenditures. Volume 4, U.S. Code Cong. & Admin. News at p. 7878.

The Committee expressed concern over increasing hospital costs and improper utilization of existing facilities. Volume 4, U.S. Code Cong. & Admin. News at pp. 7893-4. The Committee in fact stated:

> The recent rapid acceleration in the costs of personal health services, far outstripping the rate of inflation in other sectors of the economy, has caused the Committee great concern. Although recognizing the increase in costs experienced by health care providers attributable to general inflation, the Committee, wishes to express its concern with respect to the disproportionately high rate of increase in costs of health care services. Volume 4, U.S. Code Cong. & Admin. News at p. 7895.

The Committee attributed many of the cost and duplication problems in the health care industry to reimbursement programs like the ones these defendants sponsor. The legislative history indicates to this Court that any attempts by companies such as these defendants to reduce costs and duplication were to be welcomed and were considered essential to a successful program of cost reduction. In summarizing the Act, the Committee stressed:

> The long-range goal plan is expected to provide for the prevention of unnecessary duplication of resources and assure that quality health services will be available and accessible in a manner which assures continuity of care at reasonable costs for all residents of the area, and which is responsive to the needs and resources of the area. U.S. Code Cong. & Admin. News at p. 7887.

Further, the Committee indicated:

> A health planning agency is directed to seek to implement its long-range goal plan and short-term priorities plan with the assistance of individuals and public and private entities in its health area. In so doing, the agency is directed to provide technical assistance, to the extent practicable, to such entities in bringing about consistency with its health plan. Volume 4, U.S. Code Cong. & Admin. News at p. 7888.

This interpretation of the legislative history is further supported by Representative Paul Rogers in debates over subsequent amendments to this Act. Representative Rogers expressed concern over interpretations of the National Health Planning and Resource Development Act of 1974:

> Concern has been expressed that HSA's and health care providers who voluntarily carry out the mandates of the health planning laws (titles XV and XVI of the Public Health Service Act) may be in violation of the antitrust laws.
>
> The antitrust laws prohibit actions which have the effect of restraining trade or competition. We have found, however, that there is minimal price competition within some parts of the health sector and that often the only competition is around the provision of services. One undesirable result of service competition has been that hospitals and other health care providers have acquired duplicative and expensive equipment and facilities which have led to higher costs for the consumer. In enacting Public Law 93-641, which added titles XV and XVI to the Public Health Service Act, the Congress made a specific judgment that con-

trol of the development of health care facilities was needed even though price and service competition might be restrained, and created a health planning system that could promote the efficient use of health resources through the regulation of and voluntary action by providers.

Title XV requires HSA's to bring together both consumers and providers to plan for an efficient health care system that will meet the area's needs. The HSA governing body is to make decisions in its health systems plan and in appropriateness [sic] review recommendations that affect market allocation . . . . In doing so, the HSA may develop institution-specific recommendations; . . . or develop broader recommendations, such as, three cardiac catheterization laboratories in the area should be consolidated. In either case, it is congressional intent that providers and consumers work together in cooperation with the HSA to determine how best to carry out such recommendations. Without the voluntary cooperation of providers, the provision of title XV dealing with the development of a plan and the review of existing institutional health services could not be carried out.

. . . congressional intent was for the HSA, the congressional intent was for the HSA, the provider seeking the certificate of need and other providers which might seek to provide similar services to coordinate their activities to assure that new institutional health services are developed in accordance with the health systems plan for the area.

Although Public Law 93-641 contains no specific exemption from the antitrust laws, an analysis

> of the activities required of HSA's and providers indicates that Congress sanctioned actions which might otherwise be in violation of our antitrust laws. The intent of Congress was that HSA's and providers who voluntarily work with them in carrying out the HSA's statutory mandate should not be subject to the antitrust laws. If they were, Public Law 93-641 simply could not be implemented. Congressional Record House, No. 18 Part 1, p. H11962-H11963.

National Gerimedical Hospital & Gerontology Center v. Blue Cross, supra, 479 F. Supp. at 1021-23.

We adopt the district court's discussion, as set out above. We affirm the district court's holding; the doctrine of implied immunity applies to Blue Cross' voluntary cooperation with the congressionally designated HSA in requiring Hospital to obtain need approval from MAHSA prior to applying for a Blue Cross membership contract.

Appellee Blue Cross also argues that the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15, exempts the challenged conduct from the federal antitrust laws. We agree, in all respects, with the district court's holding that *Group Life & Health Insurance Co. v. Royal Drug Co., Inc.*, 440 U.S. 205 (1979) (defining "the business of insurance" in connection with the McCarran-Ferguson Act) controls. *National Gerimedical Hospital & Gerontology Center v. Blue Cross, supra,* 479 F. Supp. at 1016-19. Thus, we hold that the McCarran-Ferguson Act insurance exemption is not applicable in this case.

The district court is affirmed.

A true copy.

Attest:

CLERK, U.S. COURT OF APPEALS, EIGHTH CIRCUIT.

APPENDIX B

State Certificate of Need Legislation and Section 1122 Agreements

State	Certificate of Need Legislation	Effective (Termination) Date §1122 Agreement
ALABAMA	Ala. Code §§ 22-21-260 *et seq.* (1977)	9/18/73 (6/30/80)
ALASKA	Alaska Stat. §§ 18.07.011 *et seq.* (1977)	4/1/74
ARIZONA	Ariz. Rev. Stat. §§ 36-401 *et seq.* (1971)	
ARKANSAS	Ark. Stat. Ann. §§ 82-2301 *et seq.* (1975)	7/1/73
CALIFORNIA	Cal. Health & Safety Code §§ 437 *et seq.* (1969)	
COLORADO	Colo. Rev. Stat. §§ 25-3-501 et seq. (1973)	3/1/74 (6/30/79)
CONNECTICUT	Conn. Gen. Stat. §§ 19-73a *et seq.* (1969)	
DELAWARE	Equitable Health Planning and Review, Del. Code tit. 16, §§ 9301 *et seq.* (1978)	7/1/73
DISTRICT OF COLUMBIA	1978 D.C. Code Legis. & Admin. Serv. 2-43, §§ 2 *et seq.* (1977)	
FLORIDA	Fla. Stat. §§ 381.493 *et seq.* (1972)	1/1/73 (6/30/78)

State	Certificate of Need Legislation	Effective (Termination) Date §1122 Agreement
GEORGIA	Ga. Code §§ 88-3301 *et seq.* (Supp. 1974)	2/27/74
HAWAII	Haw. Rev. Stat. §§ 323D-1 *et seq.* (1974)	8/16/73 (2/28/77)
IDAHO	Idaho Code §§ 39-4901 *et seq.* (Supp. 1980)	2/1/74 (9/30/80)
ILLINOIS	Ill. Rev. Stat. ch. 111 1/2, §§ 1151 *et seq.* (1974)	
INDIANA	Ind. Code §§ 16-1-3.2 *et seq.* (1980)	7/1/73
IOWA	Iowa Code §§ 135.61 *et seq.* (1977)	3/7/73
KANSAS	Kan. Stat. §§ 65-4801 *et seq.* (1972)	
KENTUCKY	Ky. Rev. Stat. §§ 216B.101 *et seq.* (1980) (original version at Ky. Rev. Stat. §§ 216.405 *et seq.* (1972))	3/15/74
LOUISIANA		5/16/73
MAINE	Me. Rev. Stat. tit. 22, §§ 301 *et seq.* (1978)	3/1/73
MARYLAND	Md. Health Code Ann. §§ 556 *et seq.* (1968); Md. Executive and Administrative Department Code Ann. §§ 59C-59L, 206-206D (1968)	2/15/74 (6/30/78)

State	Certificate of Need Legislation	Effective (Termination) Date §1122 Agreement
MASSACHUSETTS	Mass. Gen. Laws ch. 6, § 166; ch. 6A, § 16; ch. 17, § 3; ch. 111, §§ 25B-25H, 51, 52, 71, 73A; ch. 111B, §§ 6, 6A; ch. 155, § 2B (1971)	
MICHIGAN	Mich. Stat. Ann. §§ 14.15(22101) *et seq.* (Supp. 1972)	12/14/73
MINNESOTA	Minn. Stat. §§ 144.50 *et seq.*, §§ 144A.01 *et seq.*, §§ 145.832 *et seq.* (Supp. 1971)	2/25/74
MISSISSIPPI	Miss. Code Ann. §§ 41-7-171 *et seq.* (Supp. 1979)	6/25/73
MISSOURI	Mo. Rev. Stat. §§ 197.300 *et seq.* (1979)	6/16/73 (7/1/76) Reinstated 9/20/79
MONTANA	Mont. Rev. Codes Ann. §§ 50-5-101 *et seq.* (1975)	2/26/74 (2/80)
NEBRASKA	Neb. Rev. Stat. §§ 71-5801 *et seq.* (Supp. 1979)	2/26/73
NEVADA	Nev. Rev. Stat. §§ 439A *et seq.*, §§ 449.001 *et seq.* (1971)	3/15/74 (3/80)

State	Certificate of Need Legislation	Effective (Termination) Date §1122 Agreement
NEW HAMPSHIRE	N.H. Rev. Stat. Ann. §§ 151-C:1 *et seq.* (Supp. 1979)	4/1/73 (6/30/80)
NEW JERSEY	N.J. Rev. Stat. §§ 26:2H-1 *et seq.* (Supp. 1971)	2/28/74
NEW MEXICO	N.M. Stat. Ann. §§ 24-3A-1 *et seq.* (1978)	7/1/73
NEW YORK	N.Y. Pub. Health Law §§ 2800 *et seq.* (1964); N.Y. Mental Hyg. Law §§ 31.01 *et seq.* (1964)	2/28/74 (6/30/80)
NORTH CAROLINA	N.C. Gen. Stat. §§ 131-175 *et seq.* (Supp. 1978)	4/2/73
NORTH DAKOTA	N.D. Cent. Code §§ 23-17.2-01 *et seq.* (1971)	2/28/74
OHIO	Ohio Rev. Code Ann. §§ 3702.51 *et seq.* (1975)	6/28/74 (6/1/78)
OKLAHOMA	Okla. Stat. tit. 63, §§ 2651 *et seq.* (Supp. 1971)	2/27/74
OREGON	Or. Rev. Stat. §§ 441 *et seq.*, §§ 442.015 *et seq.* (1971)	3/1/74 (6/30/80)
PENNSYLVANIA	35 Pa. Cons. Stat. Ann. §§ 448.101 *et seq.* (Supp. 1979)	3/1/73 (8/1/80)

State	Certificate of Need Legislation	Effective (Termination) Date §1122 Agreement
RHODE ISLAND	R.I. Gen. Laws §§ 23-15-1 *et seq.*, §§ 23-16-1 *et seq.*, §§ 23-17-1 *et seq.* (1968)	
SOUTH CAROLINA	S.C. Code §§ 44-7-100 *et seq.* (1971)	3/15/74
SOUTH DAKOTA	S.D. Compiled Laws Ann. §§ 34-7A-22 *et seq.*, §§ 34-12-1, 34-12-2, 34-12-14 (1972)	
TENNESSEE	Tenn. Code Ann. §§ 53-5401 *et seq.* (1973)	
TEXAS	Tex. Rev. Civ. Stat. Ann. art. 4418h, §§ 1.01 *et seq.* (1975)	
UTAH	Utah Code Ann. §§ 26-33-1 *et seq.*, §§ 26-34-1 *et seq.* (Supp. 1979)	2/26/74 (7/1/79)
VERMONT	Vt. Stat. Ann. tit. 18, §§ 2400 *et seq.* (Supp. 1979)	1/2/75 (7/1/79)
VIRGINIA	Va. Code §§ 32.1-93 *et seq.* (1973)	1/2/75 (7/1/79)
WASHINGTON	Wash. Rev. Code §§ 70.40.010 *et seq.* (Supp. 1971)	2/1/74 (7/1/78)

State	Certificate of Need Legislation	Effective (Termination) Date §1122 Agreement
W. VIRGINIA	W. Va. Code §§ 16-2D-1 *et seq.* (1977)	3/15/77
WISCONSIN	Wis. Stat. §§ 150.001 *et seq.* (Supp. 1977)	9/1/73 (7/1/78)
WYOMING	Wyo. Stat. §§ 35-2-101 *et seq.* (1977)	2/28/74 (6/30/79)

JAN 12 1981

No. 80-802

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER, *Petitioner,*

v.

BLUE CROSS OF KANSAS CITY AND BLUE CROSS ASSOCIATION, *Respondents.*

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

REPLY BRIEF FOR THE PETITIONER

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TABLE OF CONTENTS

		PAGE
I.	The Conduct At Issue Was Not Authorized By The Planning Act	1
II.	The Court Of Appeals Has Created Unlimited Immunity For Totally Voluntary Conduct Undertaken By Private Parties With No Governmental Supervision	3
III.	The Issue Presented Is Of Great And Continuing Public Importance	7

TABLE OF AUTHORITIES

CASES: PAGE

California Retail Liquor Dealers Association v. *Midcal Aluminum, Inc.*, 445 U.S. 97 8

Desgranges Psychiatric Center v. *Blue Cross and Blue Shield of Michigan*, 1980-81 Trade Cas. (CCH) ¶ 63,576 (Mich. Cir. Ct. 1980) 8

Group Life & Health Insurance Co. v. *Royal Drug Co.*, 440 U.S. 205 9

Hospital Building Co. v. *Trustees of Rex Hospital*, 425 U.S. 738 ..... 8, 9

St. Bernard Hospital v. *Hospital Service Association of New Orleans, Inc.*, 618 F.2d 1140 (5th Cir. 1980)... 9

United States v. *Philadelphia National Bank*, 374 U.S. 321 6

Virginia Academy of Clinical Psychologists v. *Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980) 4

STATUTES AND LEGISLATIVE MATERIALS:

42 U.S.C. § 300ℓ-2(c)(1) 1, 2

Health Planning and Resources Development Amendments of 1979, Act of October 4, 1979, Pub. L. No. 96-79, § 110(d)(1), 93 Stat. 603-04 (1979) 6

Health Planning and Resources Development Amendments of 1979: Hearings before the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce on H.R. 3041 and 3167, H.R. Rep. No. 96-12, 96th Cong., 1st Sess. (1979) 6

H.R. Rep. No. 96-420 (Conference Rep.), 96th Cong., 1st Sess. (1979), *reprinted in* [1979] U.S. Code Cong. & Ad. News 1422..... 7

Mo. Ann. Stat. §§ 197.300 *et seq.* (Vernon Supp. 1980) . 5

National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, § 1512(b)(4), 88 Stat. 2235 (1974) 6

Table of Authorities Continued

OTHER AUTHORITIES: PAGE

E. Taylor, "Participation in Shared Programs Up Sharply, Survey Discloses," 51 *Hospitals* 192 (July 16, 1977) 9

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On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

REPLY BRIEF FOR THE PETITIONER

I.

The Conduct At Issue Was Not Authorized By The Planning Act.

Respondent Blue Cross of Kansas City ("Blue Cross") asserts that the conduct in question here was "specifically authorized and encouraged" by the Planning Act (Blue Cross Br., Question Presented); was "expressly authorized and intended under the directives of the Health Planning Act" (Blue Cross Br. at 22 n.16); was "deemed necessary by [the health systems agency] to assist in implementation of the [Health Systems Plan]" and was "directed and contemplated" under the Act. (Blue Cross Br. at 22 n.16.) Respondent Blue Cross Association ("BCA") argues, perhaps correctly, that this is how the conduct in question here was viewed by the courts below. (BCA Br. at 11-13.)

If the issue in this case was liability for conduct *required* by federal legislation, as respondent would have this Court believe, this would be a different case from what it is. The courts below relied on Section 300*l*-2(c)(1) of the Act to support their assump-

tion that the challenged conduct was somehow demanded by the Act, but the actual language of that provision simply does not support that conclusion:

> A *health systems agency* shall implement its HSP and AIP, and in implementing the plans it shall perform at least the following functions:
>
> (1) *The agency* shall seek, *to the extent practicable*, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area. (Emphasis added.)

First, the provision plainly speaks to "the agency" and not to private entities; to the extent this provision requires, authorizes or encourages *any* conduct, it is *only* conduct by the agency itself. On this point, the record in this case is clear: the action complained of here was *not* taken by, or at the request of, a health systems agency. As respondent BCA concedes, the Blue Cross policy was "unilaterally adopted."[1] (BCA Br. at 11.) The conduct was neither sought, approved, nor even reviewed by any federal or state agency. This is volitional private conduct, and it cannot be shielded from antitrust scrutiny by mischaracterizing it as being statutorily mandated by the Planning Act.

Second, the plain language of Section 300*l*-2(c)(1) shows that Congress recognized there would be limits to private cooperation with an HSA. Unless we are to assume they are mere surplusage, the words "to the extent practicable" demonstrate that understanding. Boycotts, bribery, threats, and other forms of coercion may be effective tools in accomplishing a particular result, but they are forbidden to private and public entities alike by criminal statutes. It does not require any flight of fancy to assume that Congress recognized that illegal, coercive conduct by private entities, even if thought helpful by the HSA, would not be desirable and should not be encouraged. Nevertheless, this is respondents' argument: not that the boycott of National

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[1] While BCA may mean to exclude itself and others from the decision by this language, which begs the ultimate question at stake in this litigation, at a minimum this admission concedes the conduct challenged here was not undertaken pursuant to any governmental mandate.

Gerimedical was reasonable and thus does not violate the Sherman Act, but rather that it should not even be tested under traditional antitrust standards, because the Planning Act calls for the HSA to seek the "assistance" of private entities "to the extent practicable." The courts below have erroneously accepted this creative misuse of statutory language. This Court should correct that error.

II.

The Court Of Appeals Has Created Unlimited Immunity For Totally Voluntary Conduct Undertaken By Private Parties With No Governmental Supervision.

Both respondents attack petitioner's characterization of the opinion below as granting a "blanket exemption" from antitrust scrutiny for private conduct arguably consistent with the goals of the Planning Act. Respondent BCA argues that the word "blanket" does not appear in the opinion (BCA Br. at 16), and respondent Blue Cross asserts that this Court should look solely at the "holding" of the court of appeals, and ignore the context of the court's opinion and the opinion of the district court so heavily relied on by the court of appeals. (Blue Cross Br. at 5-7.)[2]

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[2] Blue Cross, in a massive understatement, states that "[t]here is language in the *District Court's* opinion which arguably could extend beyond the facts presented." (Blue Cross Br. at 5 n.2.) In fact, of course, the district court left no doubt that its decision was premised on the existence of a "blanket" exemption from the antitrust laws:

> In determining if an exemption to the antitrust laws can be implied, courts have distinguished two types of exemptions — specific and blanket. A specific repeal of the antitrust laws implies an exemption only for particular conduct or activity. An exemption for an entire legislative scheme would be a blanket exemption. Courts that have upheld claims of implied repeal have normally limited this repeal to the specific conduct challenged in that particular case; *however, in the circumstances of this case defendant's claim is that the entire concept of the National Health Planning and Resource Development Act presupposes non-application of the antitrust laws so that any activity authorized and within the scope of that Act is free from antitrust challenges.* The proper issue in this case

Indeed, says respondent Blue Cross, the opinion of the court of appeals "merely recognizes that conduct of private parties in compliance with federal legislation does not violate the antitrust laws." (Blue Cross Br. at 12.)

This is an accurate description of the opinion below only if one understands the phrase "in compliance with" to mean totally volitional conduct subject to no statutory or administrative mandate, direction, control, or review,[3] undertaken by private parties (including, as in this case, combinations of competitors)[4] who

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> then is whether there is a plain repugnancy between the scope of the National Health Care Planning and Development Act and the antitrust laws. Another formulation of this same test of somewhat easier application is whether an exemption to the antitrust laws is necessary to make this statutory scheme effective. The Court believes the answer is yes. *In the Court's view, voluntary cooperation of the entire health care industry, including third party payors, is essential to the success of the Act.* (Pet. App. at 32a; 479 F. Supp. at 1021) (emphasis added.)

As noted by the Solicitor General, "[s]ince the court of appeals did not limit or qualify the district court's recognition of a blanket immunity, the scope of that immunity appears to be sweeping." (Amicus Curiae Br. at 5.)

[3] BCA argues that National Gerimedical could have attempted to convince MAHSA to reverse its finding of hospital bed oversupply, and that this would be a satisfactory mechanism for review of the Blue Cross boycott. (BCA Br. at 19 n.26.) But the relevant issue is whether there was any administrative oversight over the anticompetitive conduct in question — in this case, the denial of participating hospital status by a combination of existing competitors to a newcomer in the market. In fact, this litigation is the only opportunity for National Gerimedical to gain any review of that boycott.

[4] Virtually all of National Gerimedical's competitors are Blue Cross member hospitals, and representatives of several of those hospitals served on the Blue Cross Board of Trustees during the time here relevant. (Record on Appeal at 4, 261, 272-79, 296-98.) Thus, Blue Cross is clearly an organization of competing providers whose alleged boycott of a potential newcomer to the market is an actionable concerted refusal to deal under section 1 of the Sherman Act. *Cf. Virginia Academy of Clinical Psychologists* v. *Blue Shield of Virginia*, 624 F.2d 476, 480-81 (4th Cir. 1980).

may have private economic or anticompetitive motives for their conduct. Petitioner submits that a broader antitrust exemption would be difficult to imagine. This result was clearly never intended, and in fact was implicitly rejected, by Congress. (*See, infra*, at pp. 6-7.)

The decision below misapplies the implied repeal standards articulated by this Court. The court of appeals apparently accepted the district court's assumption — totally without support in either the record below or logic — that antitrust liability for private entities would "foreclose" the accomplishment of the goals sought by the Planning Act. Therefore, concluded the court of appeals, there is "clear repugnancy" between the Act and the antitrust laws. (Pet. App. at 11a; 628 F.2d at 1056.) But the Planning Act neither calls for nor requires any concerted private action, much less boycotts by dominant insurance carriers. The Act does encourage an HSA to "seek, to the extent practicable . . . the assistance of public and private entities," but the HSA here had no regulatory power at all,[5] and in any event never asked Blue Cross to undertake this conduct. The courts below ignored both the statute and the facts in their conclusions of "clear repugnancy," thus failing to follow the analytical standards established by this Court.

With respect to legislative intent, the court of appeals merely adopted *in toto* the district court's flawed analysis, concluding that Congress must have intended "to immunize this type of voluntary action from the antitrust laws." (Pet. App. at 11a; 628 F.2d at 1056.) But Congress did not say so. Nowhere in the court's

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[5] During all times here relevant, Missouri had no compulsory certificate of need program in effect. Consequently, National Gerimedical was not required to undergo any need review. Furthermore, when Missouri enacted a certificate of need statute in 1979 (Mo. Ann. Stat. §§ 197.300 *et seq.* (Vernon Supp. 1980)), National Gerimedical and all similarly situated hospitals were deemed to have received certificates of need by the legislation itself. Thus, National Gerimedical at no time was required by any federal or state statute to undergo need review, and was boycotted by Blue Cross solely for failing to comply with the need review requirement unilaterally imposed by Blue Cross.

opinion is there any mention of the fact that Congress has twice specifically considered the immunity issue, or that it has included a provision in the Act which affords a narrowly delimited immunity from antitrust (and other) damages actions for HSAs, their employees and members. Significantly, that provision does not include any immunity for private parties.

As the oft-quoted remarks of Representative Rogers show,[6] the relationship of the Planning Act to the antitrust laws has hardly been a hidden issue. Indeed, the potential conflict was recognized at the time of the original legislation and Congress sought to deal with it by expressly immunizing individual members or employees of an HSA from damages actions, including those brought under the antitrust laws.[7] At the time of the 1979 Amendments, the issue had apparently become even more visible, and the exemption was broadened to include the HSA itself.[8] Significantly, Congress continually resisted attempts to extend immunity to providers and other private parties. Although it was specifically urged in 1979 to enact an immunity provision that also would have covered private parties[9], it declined to do so. Importantly, even

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[6] Both the district court and the court of appeals relied primarily on remarks by Representative Rogers made on the floor long after the Act was passed to support their conclusion that the Planning Act impliedly repealed the antitrust laws. (Pet. App. at 34a-36a, 479 F. Supp. at 1022-23; Pet. App. at 13a-15a, 628 F.2d at 1056-57.) As this Court has recognized, however, such postenactment statements by a single member are of doubtful value as an indicator of Congressional intent. *See United States* v. *Philadelphia National Bank*, 374 U.S. 321, 349.

[7] *See* National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, § 1512(b)(4), 88 Stat. 2235 (1974).

[8] *See* Health Planning and Resources Development Amendments of 1979, Act of October 4, 1979, Pub. L. No. 96-79, § 110(d)(1), 93 Stat. 603-04 (1979).

[9] *See* Health Planning and Resources Development Amendments of 1979: Hearings before the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce on H.R. 3041 and 3167, H.R. Rep. No. 96-12, 96th Cong., 1st Sess. 187-88, 641 (1979) (American Health Planning Association urging extension of immunity to "organizations, their employees,

the 1979 broadened immunity provision was limited to conduct undertaken without gross negligence or malice, and "required of, or authorized to be undertaken by, the agency."

In short, Congress clearly perceived this issue, and dealt with it in the way it thought appropriate. The respondents here are not health systems agencies, nor members or employees thereof, and the activities challenged here were concededly not "required of, or authorized to be undertaken by," an HSA. Thus, they remain fully subject to antitrust scrutiny, and the conclusion of the courts below that Congress intended some broader immunity is unwarranted and should be reversed.

III.

The Issue Presented Is Of Great And Continuing Public Importance.

Both respondents fervently argue that the facts in this case are unique because Missouri did not have certificate of need legislation in effect when this action arose. It is said that this case is not worthy of this Court's review because its specific facts are not likely to arise again. (BCA Br. at 6-7; Blue Cross Br. at 7-10.) Indeed, Blue Cross asserts that this case is the only one in which implied repeal is likely to be the "sole" issue, and then blandly concludes that all other cases arising under the Act will all be decided under the *Parker* v. *Brown* or *Noerr-Pennington* doctrines. (Blue Cross Br. at 9.)

These arguments unduly demean the basic issue which is clearly presented here. The principle on which this case rests — that purely voluntary conduct by private parties unsupervised by

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Board members and agents who voluntarily follow the recommendation of a SHPDA or HSA made in conformance with the requirements of this act"; American Medical Association urging that "[a] new section would be added to exempt actions taken in meeting the requirements of the Act from federal antitrust laws"). The Conference Committee rejected the proposed Senate version which would have extended immunity to "agents and consultants" of the HSA. *See* H.R. Rep. No. 96-420 (Conference Rep.), 96th Cong., 1st Sess. 66 (1979), *reprinted in* [1979] U.S. Code Cong. & Ad. News 1422, 1434.

any governmental agency may be exempt from antitrust scrutiny -- is far broader than the specific facts of this case. The decision below, if allowed to stand, will greatly expand the doctrine of implied repeal.

Moreover, respondents claim too much. As this Court clearly established in *California Retail Liquor Dealers Association* v. *Midcal Aluminum, Inc.*, 445 U.S. 97, the state action doctrine applies only where the challenged restraint is one "clearly articulated and affirmatively expressed as state policy," and "the policy . . . [is] 'actively supervised' by the State itself." 445 U.S. at 105. The *Noerr-Pennington* doctrine protects only advocacy before governmental bodies. Voluntary conduct undertaken by health care providers and insurers in ostensible support of the cost containment goals contained in the Planning Act will generally fall outside both exemptions, leaving the conduct fully subject to antitrust scrutiny, unless the antitrust laws are held, as in this case, to be impliedly repealed.

Among various ways in which the question can appear, the implied repeal issue is likely to arise in future cases involving the denial by Blue Cross of participating hospital status to newcomers in the market,[10] as well as other similar actions involving provider agreements which may have the effect of depriving the newcomer of the ability to compete fairly with existing providers. For example, in *Hospital Building Co.* v. *Trustees of Rex Hospital*, 425 U.S. 738, plaintiff alleged, *inter alia*, that Blue Cross had participated with an HSA official, the North Carolina Hospital Association, the defendant, and other parties in an overall scheme to prevent proprietary hospitals from gaining a place in the

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[10] Despite respondents' contentions to the contrary, such denials by Blue Cross are clearly not limited to the specific factual situation in this case, and may occur whether or not a state certificate of need program is in effect. *See Desgranges Psychiatric Center* v. *Blue Cross and Blue Shield of Michigan*, 1980-81 Trade Cas. (CCH) ¶63,576 (Mich. Cir. Ct. 1980) (defendant's refusal, pursuant to a statewide moratorium designed to control costs, to allow participation by a new outpatient clinic held violative of state antitrust laws where facility had obtained a certificate of need from state regulatory agency.)

market by imposing a discriminatory reimbursement formula on proprietary hospitals that was not made applicable to non-proprietary hosptials.[11] *Noerr-Pennington* is clearly no shield for such conduct, and the state action doctrine might well not apply. Yet, under the decision below, such voluntary actions would be immunized from antitrust attack, despite this Court's observation that "exempting provider agreements from the antitrust laws would be likely in at least some cases to have serious anticompetitive consequences." *Group Life and Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205, 232 n.40.

Nor is the impact of the decision below limited to voluntary actions taken by Blue Cross in ostensible pursuit of the cost containment goals of the Planning Act. For example, if several hospitals agree to allocate the market they serve for the ostensible purpose of reducing costs, such action would hardly be protected by either the state action or the *Noerr-Pennington* doctrines. Nevertheless, under the decision below, such cartel agreements would be argued to be exempt from antitrust review under the implied repeal doctrine. The same would apply to various "sharing" and other types of cooperative agreements among hospitals, which are rapidly spreading throughout the country.[12] Similarly, agreements on wage scales or room rates, made in the name of cost containment, would certainly be defended as immune from antitrust scrutiny under the decision below, even though neither the state action nor the *Noerr-Pennington* exemptions would even be arguably available. In short, the implied

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[11] *See* Plaintiff's Brief in Opposition to Defendants' Motion for Summary Judgment, *Hospital Building Co.* v. *Trustees of Rex Hospital*, Civ. No. 4048 (E.D.N.C. 1980), at 17-18. Plaintiff also alleged that Blue Cross had earlier denied participating hospital status to another proprietary hospital based on the same type of determination of need policy which is at issue in this case. *Id.* at 5-6.

For another case involving allegations similar to those in *Rex Hospital, see St. Bernard Hospital* v. *Hospital Service Ass'n of New Orleans, Inc.*, 618 F.2d 1140 (5th Cir. 1980).

[12] *See* E. Taylor, "Participation in Shared Programs Up Sharply, Survey Discloses," 51 *Hospitals* 192 (July 16, 1977).

repeal issue can arise in many types of cases involving voluntary anticompetitive conduct by health care providers and insurers allegedly undertaken to serve the goals of the Planning Act. The decision below invites such conduct. It should be reviewed by this Court to delimit the proper scope of the implied repeal doctrine in this area.

CONCLUSION

The questions raised are substantial, and of serious importance in the development of antitrust law. The petition for certiorari should be granted.

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IN THE

Supreme Court of the United States

October Term, 1980

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER,

Petitioner,

v.

BLUE CROSS OF KANSAS CITY AND BLUE CROSS ASSOCIATION,

Respondents.

On Petition For A Writ of Certiorari To The United States Court of Appeals For The Eighth Circuit

REPLY OF RESPONDENT BLUE CROSS ASSOCIATION TO BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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REPLY OF RESPONDENT BLUE CROSS ASSOCIATION TO BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

Respondent Blue Cross Association submits this brief in reply to the Brief for the United States as Amicus Curiae.

The arguments presented by the amicus suffer from three critical flaws: (1) Their premise—that the Court of Appeals conferred a "blanket" immunity—is erroneous; (2) The assertion that Congress intended to encourage competition in the provision of inpatient hospital services is manifestly incorrect; and (3) The claim that the Antitrust Division's business review program is being hampered by the decision of the Court of Appeals is without foundation.

1. **The Court of Appeals' decision confers no blanket immunity.** As explained in our brief (Section III.C., pages 16-17), the Court of Appeals did not hold that the Health Planning

Act of 1974 conferred a "blanket" antitrust immunity, but confined its holding to the facts of this case. The amicus charges that the Court of Appeals failed to "limit or qualify" the District Court's purported recognition of a "blanket" immunity, and instead granted immunity for "[a]lmost any form of exclusionary conduct [which] can be viewed as falling within the purposes of the [Health Planning Act of 1974]." (Amicus Br. at 5-6). This characterization is refuted by the very structure of the Court of Appeals' decision: Although the Court of Appeals adopted the District Court's discussion of legislative history, it specifically substituted its own analysis of the scope of implied repeal and neither applied nor even mentioned a "blanket" immunity. (App. 7a-11a). Moreover, although the amicus asserts that the Court of Appeals' analysis conflicts with the standards established by this Court (Amicus Br. at 7-13), the Court of Appeals cited and carefully adhered to each of these standards, as elaborated in our brief (at pages 16-17).[1]

2. Congress did not intend to encourage competition for inpatient services. The amicus, like petitioner, erroneously asserts that the Health Planning Act of 1974 and the 1979 amendments call for the "strengthening of competition" in the circumstances of this case. (Amicus Br. at 12-13). As established in our brief (Sections III.A. and B., pages 13-16), while Congress encouraged the strengthening of competition, where appropriate, in the provision of *outpatient* services, it specifically rejected competition in the provision of *inpatient* services. The interpretation presented by the amicus fails to recognize the distinction drawn in the Act's explicit provisions between services "for which competition appropriately allocates supply" and services "for which competition does not or will not appropriately allocate supply." 42 U.S.C. §300k-2(b)(2), (3).

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[1] The comparison by amicus of Blue Cross' conduct with the conduct involved in Fashion Originators' Guild v. FTC, 312 U.S. 457 (1941) is unwarranted. (Amicus Br. at 14-15). As the Court of Appeals held (App. 9a-10a), and unlike the situation in *Fashion Originators*, there *was* a regulatory scheme operating in this case. Petitioner, however, chose to ignore it, while Blue Cross chose to honor it.

3. The Antitrust Division's Business Review Procedure is not hindered by the decision of the Court of Appeals. Although the amicus contends that the decision of the Court of Appeals is "in conflict" with certain Business Review Letters prepared by the Antitrust Division of the Department of Justice (Amicus Br. at 6-7), no such conflict exists. The cited letters granted clearance to a number of health care activities, but expressed reservations with regard to agreements among hospitals to limit services. The Court of Appeals did not address this subject, and the letters did not address the Blue Cross conduct examined by the Court of Appeals. The amicus, however, assumes that the Court of Appeals' decision conferred a "blanket" immunity which would extend to almost any conduct, including agreements among hospitals, and consequently would conflict with the advice offered in the letters. (Amicus Br. at 7). Since, as noted above, there was no "blanket" immunity, such conflict is illusory.

Furthermore, the Antitrust Division has rendered advice since the release of the Court of Appeals' decision on the very subject which the amicus claims has been thrown into a state of confusion. The Business Review Letter of August 27, 1980 (which appears in the amicus brief at pages 12a-14a) was issued subsequent to the decision of the Court of Appeals, yet the Antitrust Division rendered advice regarding agreements between hospitals to limit services without even mentioning the Court of Appeals. Although the amicus suggests that HSA's and health care providers may have become uncertain as to which activities they can engage in without risking antitrust liability (Amicus Br. at 7), any such uncertainty is not the result of a conflict between the Antitrust Division and the Court of Appeals, because the two never examined the same conduct. The position stated by the Antitrust Division is simply that the Health Planning Act does not create "a complete antitrust exemption." (Amicus Br. at 6). The decision of the Court of Appeals is not inconsistent with that position.[2]

* * *

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[2] It should be recognized that while the arguments of the amicus represent the views of the Antitrust Division, which joined in the brief, they do not purport to represent the views of the Department of Health and Human Services, which did not join.

For the reasons described above, we respectfully submit that the arguments advanced by the amicus do not establish that this case warrants further review. The petition for a writ of certiorari should be denied.

December 24, 1980

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Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF OF RESPONDENT BLUE CROSS OF KANSAS CITY IN REPLY TO BRIEF OF AMICUS CURIAE

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The Brief for the United States as Amicus Curiae does not advance any valid grounds for review of the decision below. Amicus makes only two arguments: that the decision below "leaves both the health service industry and federal antitrust enforcement officials in need of this Court's guidance," and that the Court of Appeals' decision conflicts with implied antitrust exemption standards established by this Court. The latter argument is the same as the one made in Part II of the Petition which was fully discussed in Part III of the Brief of Respondent Blue Cross of Kansas City in Opposition to the Petition. For the reasons stated in respondent's Brief in Opposition, the Court of Appeals' decision properly applies all settled prin-

ciples of implied repeal and is *not* inconsistent with prior decisions of this Court.

Amicus' first argument suffers from the same error made by petitioner. Amicus begins with the proposition that the Eighth Circuit's decision "endorses" a "blanket immunity" from the antitrust laws (Amicus Brief at 5), and then reasons that in so doing the decision below "stands in conflict with the Department's [of Justice] conclusion in these business review letters." (Amicus Brief at 7). This reasoning totally ignores the very limited scope of the Eighth Circuit's ruling. The *holding* of the Eighth Circuit permits an implied repeal only as to the *particular conduct* involved in this case under the specific circumstances in which it occurred. (See Part I of Respondent's Brief in Opposition).

It is interesting that Amicus appends to its Brief the three Department of Justice releases and business review letters dealing with proposals under the Health Planning Act. Those releases and letters actually demonstrate, very clearly, that the decision below *is in fact fully consistent with* the Department's enforcement position. Those releases and letters reflect the Department's position that its enforcement intentions must necessarily depend upon an evaluation of the specific conduct in question under the particular circumstances in which it occurred. In the letter of May 6, 1980 from Sanford M. Litvack to William G. Kopit, the Department's approach was summarized as follows:

> "Thus, we would formulate enforcement intentions with respect to specific implementation activities only upon assessment in detail of the conduct in question, the specific circumstances in which it occurs, its relationship to the goals established for health planning by Congress and to the specific objectives of relevant

> plans, whether the conduct is necessary to achieve those goals and objectives, the degree to which competition would properly allocate resources if given the opportunity, and the availability of less anti-competitive alternatives." (Amicus Brief at 8a).

Moreover, the August 29, 1980 release presented the specific factual situation of "agreements between competitors" (Amicus Brief at 13a), and the June 13, 1978 release similarly presented specific facts involving "joint action by competitors" (Amicus Brief at 22a), neither of which involves the unique factual context in which the opinion below was decided.

Thus it is quite clear that the Court of Appeals' decision in this case, which was expressly limited to the very unique facts presented, is fully consistent with the position of the Department of Justice reflected in these releases and review letters to the effect that its enforcement intentions require independent evaluation of each specific set of facts presented. The decision below does not affect, must less impair, the Department's ability to provide guidance on its enforcement intentions, and in fact is fully consistent with the Department's conclusions stated in the releases and review letters appended to Amicus' Brief.

Although respondent's Brief in Opposition to the Petition fully disposes of Amicus' second argument that the decision below conflicts with prior decisions of this Court, respondent feels compelled to correct a glaring error in Amicus' discussion of that point. Amicus reasons that scrutiny of respondents' conduct under the antitrust laws cannot give rise to the required repugnance because "there is not even a finding that Blue Cross' actions were taken to assist MAHSA in implementing its HSP. . ." (Amicus Brief at 12). This is plainly wrong, for both the District Court and the Court of Appeals specifically relied on the

fact that the challenged conduct here—requiring petitioner to obtain need approval before constructing a new hospital —actually *did* assist MAHSA in implementing its Health Systems Plan. (Petition App. A at 9a-11a; Petition App. B at 30a-33a).

Independently, the Secretary of the Department of Health and Human Services reached the same conclusions as did counsel of record for Respondent Blue Cross of Kansas City. This is illustrated by the December 17, 1980 letter from Secretary Patricia Roberts Harris of the Department of Health and Human Services to Attorney General Benjamin R. Civiletti.[1] Because of its thoughtful analysis of the respective positions and the clearly expressed opinion of that department of the executive branch of the government directly responsible for implementing the acts of Congress concerning the delivery of health services, the Secretary's letter of December 17, 1980 is reproduced in full text as follows:

December 17, 1980

The Honorable Benjamin R. Civiletti
Attorney General
Washington, D.C. 20530

Dear Mr. Attorney General:

I am writing to express my dissatisfaction with the position the Solicitor General has authorized to be taken by

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1. Late Wednesday afternoon, December 17, 1980, counsel for Respondent Blue Cross of Kansas City was called by newspaper media of Washington and informed of the letter from Secretary Harris to Attorney General Civiletti. Counsel independently obtained a copy of the letter. Then as a matter of courtesy, counsel of record for Respondent Blue Cross of Kansas City inquired and was informed by the Secretary's General Counsel that the Secretary would not object to the reproduction of the text of the letter in this Brief since the letter was already a matter in the public domain.

the United States on the Petition for a Writ of Certiorari filed with the Supreme Court in *National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City and Blue Cross Association* (Petition No. 80-802). The case was brought by the hospital to challenge Blue Cross's policy of refusing to enter into a participating hospital reimbursement agreement unless the hospital obtained a finding of need from the local health systems agency ("HSA"), consistent with the provisions of the National Health Planning and Resources Development Act of 1974 ("Act") as amended, 42 USC 300k, *et seq.* Rather than seek such a finding, the hospital filed suit claiming that Blue Cross's refusal to enter into a participating hospital reimbursement agreement constitutes an antitrust violation. Both the District Court and the Eighth Circuit held that the Act provides an implied exemption from the antitrust laws for Blue Cross's conduct and, accordingly, dismissed the complaint. This is consistent with this Department's legal interpretation of the Act and our policy for implementation of the Act.

Nonetheless, the Solicitor General has authorized the filing of an *amicus* brief supporting the hospital's position on certiorari, urging the Supreme Court to reverse the Eighth Circuit. I am very troubled by the Government taking this position, which I believe will impede implementation of the health planning process established by the Congress. In addition, I am particularly disturbed at the way in which the decision was made. In my view, this Department has been denied a fair opportunity to present its position on this matter, which is of great interest to us.

I would like to describe to you some of the background so that you will understand the strength of my feelings. For some time we have recognized the conflict between

the policy of the antitrust laws to promote competition and the policy underlying the health planning process, to coordinate health services and to eliminate unnecessary duplication. Congress established this process in recognition that competition has not worked in many areas of health care, and health planning is an important component of the Government's initiative to reduce the costs of the nation's health care system and to make that system more responsive to the needs of the people it serves.

Joan Z. Bernstein, General Counsel of this Department, and her staff have been discussing this matter with Sanford Litvack, Assistant Attorney General for the Antitrust Division, and his staff for many months. As the agency with responsibility to implement the health planning process, we initiated these discussions because we felt it necessary for the Government to provide the public with guidance on the application of the antitrust laws to the health planning process, and we sought to provide this guidance in consultation with the Antitrust Division. I think we have been quite reasonable and flexible in our efforts to develop a coherent Government position that would resolve the conflict between us in a way that would preserve the essential aims of both the antitrust and health planning laws, but to no avail.

Although we had been assured during our months of discussions with the Antitrust Division that they would consult with us before issuing any business review letters bearing on health planning, on May 6, 1980, they issued the Central Virginia Health Systems Agency business review letter without any consultation with us. The letter addressed four types of activity undertaken by HSAs: certificate of need reviews, proposed use of Federal funds reviews, appropriateness reviews, and activities to implement a health systems plan. We were gratified that the Antitrust Division stated that it does not intend to bring

enforcement action regarding the first three activities. However, the refusal to state enforcement intentions regarding plan implementation activities, perhaps the key to the whole process, was confusing, particularly because the Act expressly requires HSAs to undertake all four activities.

This letter made us increasingly concerned that the health planning process was being impaired unnecessarily by uncertainty over the application of the antitrust laws. We renewed our efforts to provide the health planning community with guidance as to the activities they could undertake to implement a health systems plan without fear of antitrust enforcement from the Department of Justice. We submitted to the Antitrust Division for their review and antitrust analysis, four hypothetical statements of conduct we regard as essential to plan implementation and not problematic from an antitrust perspective. Once again, they refused to respond or to offer more specific guidance.

During an October 10 meeting, Ms. Bernstein's staff discussed *National Gerimedical* with Antitrust Division staff. At that time, and during subsequent telephone discussion, Antitrust Division staff assured us that they would advise us if they were going to recommend to the Solicitor General that the Government participate in the case. Nonetheless, we only heard about the Antitrust Division recommendation from the Solicitor General's Office on December 10. At the time we were told that the Solicitor General would decide within two days whether to file the draft *amicus* brief prepared by the Antitrust Division.

In my view, this is an unacceptable way to develop policy, especially on such a complex and important issue. This Department and the Antitrust Division have a funda-

mental difference of opinion that has remained unresolved for some time, principally because of the Antitrust Division's adherence to their absolutist position that the Act does not exempt from antitrust scrutiny any activities to implement a health systems plan. Yet, the Solicitor General has authorized the Government to advocate the Antitrust Division position before the Supreme Court. The Department of Health and Human Services does not subscribe to this position and allowing it to be presented to the Supreme Court as the position of the United States unfairly suggests that the Government has adopted the position based on a proper decisionmaking process.

I oppose the Government filing an *amicus* brief seeking reversal of the Eighth Circuit's opinion in this case for the following reasons:

1. I believe that it is inappropriate for the Government to take a position before the Supreme Court until the position is that the health planning legislation effects a repeal of the antitrust laws, *inter alia*, for activities to implement a health systems plan and, as a matter of policy, we encourage the conduct challenged in this case.

2. The conduct at issue in this case does not give rise to any serious antitrust concern, as the Antitrust Division readily agrees. This is merely a case in which a private party conditions a benefit on a decision made by a Federally funded HSA, pursuant to a statutorily required public process, based on statutory criteria.

3. The facts of this case are unusual and not likely to recur. Almost all States now have "certificate-of-need" legislation which requires construction of health care facilities to be reviewed by an HSA. Thus, if Supreme Court guidance is desired, we

should wait for a case presenting facts more relevant to the health planning process as it now exists.

4. Finally, there is no conflict among the Circuits.

In light of these considerations, I hope the Justice Department will reverse its position and not file this brief. In any event, I hope you will appreciate my frustration and understand my obligation as Secretary to implement the health planning process and to provide guidance to the planning community, whether or not the Antitrust Division cooperates.

Sincerely yours,

Patricia Roberts Harris

It is significant that parties responsible for working in the field day to day in the delivery of health services reached the same conclusions and have adopted the same positions on this matter. That the conclusions were independently arrived at is illustrated by the fact that the Brief of Respondent Blue Cross of Kansas City in Opposition to the Petition for Certiorari was mailed as shown by the certificate of service on December 17, 1980. The letter from Secretary Harris to Attorney General Civiletti is dated the same day.

Any alleged confusion with respect to the Department of Justice business conduct review letters is generated only by the refusal of the Department of Justice to follow the decision of the Courts and of Congress. There is no confusion except any created by the opinion expressed by the Department of Justice. Congress has expressed itself. All others concerned, including three Courts, have agreed with Congress. It is respectfully submitted that in the absence of a constitutional objection which has

not been raised yet, the Department of Justice and its policy are subject to the Congressional mandate and to the decisions of Courts of Appeal.

The petition should be denied.

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BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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OCTOBER TERM, 1980

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BLUE CROSS OF KANSAS CITY AND BLUE CROSS ASSOCIATION

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

QUESTION PRESENTED

Whether the National Health Planning and Resources Development Act of 1974 created by implication an antitrust exemption for the voluntary actions of private health care insurance providers, when those actions are not required by the terms of any statute or government program and are not regulated by any government agency.

TABLE OF CONTENTS

	Page
Interest of the United States	1
Statement	1
Discussion	5
Conclusion	17
Appendix A	1a
Appendix B	10a
Appendix C	18a

TABLE OF AUTHORITIES

Cases:

California v. *FPC*, 369 U.S. 482	8, 11, 16
Carnation Co. v. *Pacific Westbound Conference*, 383 U.S. 213	16
Epstein v. *Resor*, 296 F. Supp. 214, aff'd, 421 F.2d 930, cert. denied, 398 U.S. 965	14
Fashion Originators' Guild v. *FTC*, 312 U.S. 457	15
Gordon v. *New York Stock Exchange, Inc.*, 422 U.S. 659	8
Group Life & Health Ins. Co. v. *Royal Drug Co.*, 440 U.S. 205	7, 8
Otter Tail Power Co. v. *United States*, 410 U.S. 366	8, 15
Silver v. *New York Stock Exchange*, 373 U.S. 341	8, 14
Transamerica Mortgage Advisors, Inc. v. *Lewis*, 444 U.S. 11	17
United States v. *Borden Co.*, 308 U.S. 188	16
United States v. *Colgate Co.*, 250 U.S. 300	8
United States v. *Socony-Vacuum Oil Co.*, 310 U.S. 150	11
United States v. *United Mine Workers*, 330 U.S. 258	14

PREVIOUS PAGE WAS BLANK

Statutes and regulation: Page

Sherman Act, 15 U.S.C. 1 *et seq.* 3

Section 1, 15 U.S.C. 1 1-2
Section 2, 15 U.S.C. 2 1-2

McCarran-Ferguson Act, 15 U.S.C. 1011 *et seq.* 3

National Health Planning and Resources Development Act of 1974, 42 U.S.C. (& Supp. III) 300k *et seq.* 1, 2, 3

42 U.S.C. 300k 10
42 U.S.C. (Supp. III) 300k-2 10
42 U.S.C. (Supp. III) 300k-2(a)(17) 13
42 U.S.C. (Supp. III) 300k-2(b)(1)-(3) 13
42 U.S.C. 300*l* 9
42 U.S.C. 300*l*-1(b)(4) 16
42 U.S.C. (Supp. III) 300*l*-2 2
42 U.S.C. (& Supp. III) 300*l*-2(a) 10
42 U.S.C. (Supp. III) 300*l*-2(a)(4) 4, 10
42 U.S.C. (Supp. III) 300*l*-2(b)(2) 9
42 U.S.C. 300*l*-2(c)(1) 4, 10
42 U.S.C. 300*l*-2(c)(2) 9
42 U.S.C. (Supp. III) 300*l*-2(c)-(e) 9
42 U.S.C. 300*l*-2(f)-(h) 9
42 U.S.C. (Supp. III) 300*l*-2(e) 6, 15
42 U.S.C. 300*l*-2(e)(2) 15
42 U.S.C. 300*l*-2(f) 6, 9, 15
42 U.S.C. 300*l*-2(g) 6
42 U.S.C. 300*l*-2(h) 15
42 U.S.C. (Supp. III) 300*l*-4 9
42 U.S.C. (Supp. III) 300m-2(a)(4) 9, 15
42 U.S.C. (Supp. III) 300m-2(a)(4)(B) 9
42 U.S.C. 300m-2(a)(5) 15
42 U.S.C. (Supp. III) 300m-3(d) 16
42 U.S.C. 300n-1(a) 11, 15
42 U.S.C. (Supp. III) 300n-1(b) 11, 15
42 U.S.C. (Supp. III) 300n-1(b)(12)(E) 15

28 C.F.R. 50.6 6

Miscellaneous: Page

124 Cong. Rec. H11962 (daily ed. Oct. 10, 1978).... 14
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'NTEREST OF THE UNITED STATES

The United States has a general interest in assuring that the National Health Planning and Resources Development Act of 1974, 42 U.S.C. 300k *et seq.*, is interpreted in a manner which promotes the achievement of the congressional health planning policies embodied therein. The United States also has primary responsibility for enforcing the antitrust laws. Accordingly, it has an interest in assuring that exemptions from the antitrust laws are not implied unless congressional intent to create such exemptions is clear. Moreover, to the extent that an antitrust exemption should be implied to avoid frustrating the congressional plan under a particular statute, it has an interest in assuring that the exemption is not broader than necessary to avoid that result.

The United States also has a more specific interest in the issue presented in this case. The extent, if any, to which an antitrust exemption should be recognized under the National Health Planning and Resources Development Act not only will affect law enforcement decisions concerning anticompetitive conduct by insurance providers, hospitals, and others in the health services field, but also will affect the advice given by government agencies to private parties seeking to effectuate the policies of the Health Planning Act while conforming their activities to the requirements of the antitrust laws.

STATEMENT

Petitioner brought this action against respondents Blue Cross of Kansas City and Blue Cross Association under Sections 1 and 2 of the Sherman Act, 15

U.S.C. 1 and 2, alleging that Blue Cross of Kansas City wrongfully had refused to accept petitioner as a participating member provider in its health insurance plan. The complaint further alleged that this refusal occurred because petitioner had not obtained a certificate of need from Mid-America Health Services Agency, a party alleged to be a co-conspirator in the antitrust violation but not named as a defendant in the complaint.[1]

Respondent Blue Cross of Kansas City ("Blue Cross") is a private health services corporation that sells prepaid health care plans to the public in Missouri and Kansas and contracts with health care providers to administer its plans (Pet. App. 20a). Respondent Blue Cross Association is the national parent association of Blue Cross. MAHSA is a private not-for-profit Missouri corporation established as a health systems agency ("HSA") pursuant to the National Health Planning and Resources Development Act of 1974, 42 U.S.C. (& Supp. III) 300k *et seq.* (Pet. App. 30a). Under the statute, an HSA is a private organization whose sole function with respect to new hospital construction is to advise federal and state health agencies. It serves no independent regulatory function concerning such construction. 42 U.S.C. (Supp. III) 300*l*-2.

Petitioner National Gerimedical is a general acute care hospital located in Missouri. Before opening in 1978, it sought to enter into a participating hospital agreement with Blue Cross under which National Gerimedical would receive 100% reimbursement directly from Blue Cross for all services provided to Blue Cross policyholders. Without that contract, Na-

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[1] Petitioner also alleged violations of Missouri's antitrust laws (Pet. App. 18a).

tional Gerimedical would have to bill Blue Cross subscribers who would then be reimbursed by Blue Cross for only 80% of the hospital bill (Pet. App. 20a).

Although not required to do so by either federal or state law, Blue Cross conditioned its grant of participating membership to a new hospital on the hospital's receipt of a determination from the local health systems agency (in this case MAHSA) that a new hospital was required to serve a "clearly evident need" for health care services in the area (Pet. App. 6a-7a, 21a). Petitioner, however, neither sought nor received MAHSA approval since MAHSA previously had announced that it would disapprove the addition of any new acute care hospital beds (*id.* at 7a, 21a). Consequently, Blue Cross denied National Gerimedical a participating member contract because it had not obtained a certificate of "need" from MAHSA (*id.* at 20a-21a).

Following Blue Cross's denial of National Gerimedical's application, National Gerimedical filed this action in the United States District Court for the Western District of Missouri. Respondents moved to dismiss the complaint on the ground that the National Health Planning and Resources Development Act of 1974 ("NHPRDA" or the "Act") implicitly repealed the antitrust laws to the extent that the challenged action was undertaken to effectuate the purposes of the Act.[2]

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[2] Respondents also claimed that their conduct was exempt from the antitrust laws under the McCarran-Ferguson Act, 15 U.S.C. 1011 *et seq.*, and that the prepaid medical plans at issue did not constitute a part of "trade or commerce" within the meaning of the Sherman Act (Pet. App. 18a, 38a-39a). Those claims were rejected by both courts below (Pet. App. 15a, 22a-27a, 38a-44a), and are not before this Court.

The district court granted summary judgment in respondents' favor and dismissed the complaint (Pet. App. 19a). It found a clear repugnancy between NHPRDA and the antitrust laws, and concluded that Congress intended that private actions, taken pursuant to NHPRDA and "clearly within [its] scope," be exempt from application of the antitrust laws (*id.* at 37a). In finding a conflict between NHPRDA and the antitrust laws, the court did not measure the challenged conduct against the requirements of NHPRDA. Instead, it concluded that "the entire concept of the * * * Act" revealed that Congress intended to create a blanket antitrust exemption (*id.* at 32a)—"the antitrust laws were not intended to apply to members of the health care industry clearly acting within the scope of the Act" (*id.* at 32a-33a).

The court of appeals affirmed (Pet. App. 1a-15a). It agreed with the district court that a "clear repugnancy between the Act and the antitrust laws" exists, since "the Act and regulatory scheme clearly call for the action which has now become the basis of an antitrust claim" (*id.* at 11a). The court relied in particular on 42 U.S.C. (Supp. III) 300*l*-2(a)(4) and 300*l*-2(c)(1), which describe as one of the statute's goals the prevention of "unnecessary duplication of health resources," and further provide that each HSA "shall seek, to the extent practicable, to implement its [health plans] with the assistance of individuals and public and private entities in its health service area" (Pet. App. 3a-9a). The court of appeals also adopted *in toto* the district court's finding that the legislative history revealed congressional intent "to immunize this type of voluntary action from the antitrust laws" (Pet. App. 11a-15a).

DISCUSSION

1. The court of appeals has decided an important question of federal law in a manner that leaves both the health service industry and federal antitrust enforcement officials in need of this Court's guidance.

The court of appeals' decision has a substantial adverse impact on competition and antitrust enforcement in a large sector of our economy. The health services industry employs more than five million persons,[3] and annual national health care expenditures now total more than $200 billion.[4] The district court found an implied blanket antitrust immunity under NHPRDA for the voluntary activities of all private parties in the health care field who may be said to act within the broad scope of that statute (Pet. App. 32a). The court of appeals' opinion generally endorses the district court's analysis of the immunity issue (Pet. App. 8a, 11a, 15a). Since the court of appeals did not limit or qualify the district court's recognition of a blanket immunity, the scope of that immunity appears to be sweeping.[5]

This ruling has an important effect on antitrust enforcement in the health care field. Almost any

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[3] U.S. Department of Labor, Bureau of Labor Statistics, *Employment and Earnings* 57 (Sept. 1980).

[4] Health Care Financing Administration, *Projections of National Health Expenditures: 1980, 1985, and 1990*, Health Care Financing Review 1, 11 (Winter 1980).

[5] Although this case arose in a special factual setting because Missouri did not have a "certificate of need" program in effect at the time of Blue Cross's action, the decision is not limited to such a situation. The broad scope of the exemption recognized by the court of appeals would make it applicable to many types of unregulated private conduct occurring outside of the procedures provided by statute.

form of exclusionary conduct can be viewed as falling within the purposes of NHPRDA, so long as the participants claim that their anticompetitive actions were designed to avoid what they deem to be "unnecessary" duplication of facilities or services.

For many years, the Department of Justice, through the Antitrust Division's Business Review Procedure,[6] has attempted to explain its enforcement intentions regarding conduct contemplated by persons requesting guidance. This program is designed to allow parties to proceed with lawful activities free from unnecessary fear of government law enforcement action. Within the past few years, the Department of Justice has been asked to state its enforcement intentions with respect to certain cooperative activities of health care providers and health systems agencies. While the Department has recognized that certain concerted activities appear to be contemplated by the Act,[7] it consistently has refused to recognize any implied antitrust exemption for unregulated or unsupervised concerted action by local providers affecting the supply and price of health care services. The Department has stated that "we do not believe that the Health Planning Act creates a complete antitrust exemption for all efforts by HSAs, and private parties working with HSAs, to implement health plans." Department of Justice Release (May 8, 1980).[8] The Department also has refused to

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[6] 28 C.F.R. 50.6.

[7] Such activities might include, for example, certificate of need review, federal grant review, and appropriateness review by HSAs pursuant to 42 U.S.C. (Supp. III) 300*l*-2(e), 300*l*-2(f), and 300*l*-2(g).

[8] That release is attached hereto as Appendix A.

recognize any implied antitrust exemption for proposed agreements among private health care providers to limit services offered at a new facility, when such agreements are neither authorized nor required by any regulatory agency and are not subject to governmental supervision. Department of Justice Release (Aug. 29, 1980).[9]

The court of appeals' decision in this case stands in conflict with the Department's conclusion in these Business Review Letters. As a result, health systems agencies and health care providers, as well as insurance providers like Blue Cross, understandably may be uncertain as to what activities they may engage in without concern for antitrust liability. In view of the size and importance of health services activities in our economy, resolution by this Court of the issue raised in the petition would provide important guidance to the industry and government officials.

2. The court of appeals' decision conflicts with the standards for finding an implied antitrust exemption established in numerous decisions of this Court.[10]

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[9] That release is attached hereto as Appendix B. The Department also has refused to authorize in the abstract a "voluntary cost containment program" among hospital and medical associations without receiving information about the program and its competitive impact. Department of Justice Release (June 13, 1978) (attached hereto as Appendix C).

[10] In asserting that respondents' conduct is not immunized from antitrust scrutiny, we do not imply in any sense that the conduct violates the Sherman Act. This Court is not faced here with a question of violation, but of immunity. Practices can be non-immune and still be perfectly lawful. *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 210 n.5 (1979). Following a trial or summary judgment hearing addressed to the merits, respondents' conduct may be found lawful for several reasons. Blue Cross may

In a long line of cases, this Court has prescribed strict standards governing judicial implication of statutory immunity from the antitrust laws. Exemptions from the antitrust laws are not lightly to be inferred. See, *e.g.*, *Gordon* v. *New York Stock Exchange*, 422 U.S. 659, 682 (1975); *California* v. *FPC*, 369 U.S. 482, 485 (1962). Only when a plain repugnancy is found between the antitrust laws and a subsequently enacted regulatory scheme may an implied repeal be found. *Otter Tail Power Co.* v. *United States*, 410 U.S. 366, 372 (1973). Even then, the exemption must be construed narrowly to give effect, to the greatest extent possible, to the purposes of both statutes. *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 231 (1979); *Silver* v. *New York Stock Exchange*, 373 U.S. 341, 357-359 (1963). Examination of the court of appeals' decision reveals that the conduct here in question was not measured against the foregoing standards and that, when those standards are applied to the challenged conduct, there exists no plain repugnancy between NHPRDA and the Sherman Act.

a. NHPRDA contemplates a dual system of federal and state agencies whose function is to rational-

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not have monopoly power in the insurance market in which it operates. Even if it does, its refusal to deal may not have been premised on a desire to abuse its monopoly power in the insurance market to gain an advantage in the hospital services market. See *United States* v. *Colgate Co.*, 250 U.S. 300, 307 (1919); cf. *Otter Tail Power Co.* v. *United States*, 410 U.S. 366, 377-378 (1973). Similarly, petitioner's restraint of trade claim may fail for lack of an agreement between Blue Cross and any other parties, or from failure to prove either an anticompetitive purpose or a significant anticompetitive effect.

ize the distribution of health resources. The statute, among other things, requires the states, in order to receive federal funds under public health programs, to establish "certificate of need" regulatory programs. 42 U.S.C. (Supp. III) 300m-2(a)(4)(B). Under such a program, a state administrative agency must approve capital expenditures above a threshold amount for new institutional health services. *Ibid.*

The Act also calls for the designation of some 200 health systems agencies (HSAs), which are generally private, non-profit corporations, funded by the federal government. 42 U.S.C. (Supp. III) 300*l*. Each HSA must publish a 5-year "Health Systems Plan" ("HSP") and an "Annual Implementation Plan" ("AIP") "which, when developed, will assure that quality health services will be available and accessible in a manner which assures continuity of care, at reasonable cost, for all residents of the area." 42 U.S.C. (Supp. III) 300*l*-2(b)(2). The HSA submits these plans to its state regulatory agency and also makes recommendations about how the state agency should rule on certificate of need applications. 42 U.S.C. 300*l*-2(c)(2), (f); 300m-2(a)(4). With respect to new hospital construction, the HSA exercises advisory functions only; it has no regulatory powers. 42 U.S.C. (Supp. III) 300*l*-2(c)-(e), 42 U.S.C. 300*l*-2(f)-(h).

At the time of the challenged activities in this case, MAHSA had been designated and funded as a health systems agency under the Act, 42 U.S.C. (Supp. III) 300*l*-4. The State of Missouri, however, had not implemented NHPRDA. It had not designated any state agency to review MAHSA plans, and it had not established any certificate of need program (Pet. App. 7a). Thus, any "certificate of need" findings made by MAHSA were not made pursuant to any

state program, and could not, under the Act, preclude the construction of a new hospital.

b. The court of appeals' finding of an implied exemption in this case concededly was not based on any specific statutory authorization of the challenged conduct. It was not based on any conflict with state certification of need regulations—for Missouri had no such regulatory program. Nor was it based on MAHSA's solicitation or endorsement of the challenged conduct, for the court did not find that MAHSA consulted with Blue Cross or was even aware of Blue Cross's action. Nonetheless, the court concluded that Blue Cross's conduct was "clearly call[ed] for" by the statute (Pet. App. 11a).[11] That conclusion apparently was based on 42 U.S.C. 300*l*-2(a)(4), which calls on health systems agencies to formulate plans with a view toward preventing "unnecessary duplication of health resources." The court also relied (Pet. App. 3a) on 42 U.S.C. 300*l*-2(c)(1) which provides:

> The [health systems] agency shall seek, to the extent practicable, to implement its HSP [health systems plan] and AIP [annual implementation plan] with the assistance of individuals and public and private entities in its health service area.

The statutory goal of avoiding "unnecessary duplication," however, is only one of many general goals that are to be considered by administrative and regulatory agencies in evaluating proposals and making plans. See 42 U.S.C. 300k, (Supp. III) 300k-2 and (& Supp. III) 300*l*-2(a). These goals are broadly stated

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[11] The district court had concluded that Blue Cross's certificate of need requirement "*seems to be* authorized by the Act" (Pet. App. 32a; emphasis added).

and frequently quite vague. While such generality may be acceptable, and even necessary, when delegating authority to a public agency, it hardly reflects a precise congressional determination that a category of voluntary private conduct must be immunized from the antitrust laws if the public interest in health care is to be fostered. The statutory desire to reduce "unnecessary" duplication, of course, is not self-defining. If all duplication were deemed undesirable, the adjective "unnecessary" would not have been included. Determining the point where duplication ceases to be desirable requires a careful balancing of sometimes conflicting values, *e.g.*, facilitating consumer choice versus limiting short term costs. And when new entry is denied by government authorities after balancing these various public interest factors, the statute provides explicit procedural safeguards and judicial review (42 U.S.C. 300n-1(a), (Supp. III) (b)). There is thus no evidence of any congressional desire to supplant the antitrust laws with unsupervised private decisionmaking.[12] The congressional admonition to re-

[12] There is no indication in this case that respondents' private actions were approved by the HSA. But even if they were, such approval would not immunize Blue Cross from antitrust liability. *United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. 150, 225-228 (1940); *California* v. *FPC*, *supra*, 369 U.S. at 488-489. Moreover, the antitrust laws are not rendered inapplicable simply because respondents may have believed that their exclusionary practices were in furtherance of general statutory objectives such as avoiding unnecessary expenditures or duplication of services. See *United States* v. *Socony-Vacuum Oil Co.*, *supra*, 310 U.S. at 227-228: "The fact that the [defendants'] buying programs may have been consistent with the general objectives and ends sought to be obtained under the National Industrial Recovery Act is likewise irrelevant to the legality under the Sherman Act of [their] activities * * *."

sponsible administrators to avoid "unnecessary duplication" does not even remotely suggest that Congress meant to remove private exclusionary practices from antitrust scrutiny. There is, moreover, no necessary repugnance between the statutory goals of preventing private anticompetitive practices and administering the Health Planning Act in a manner that looks to avoidance of unnecessary duplication of services.

Nor is there merit to the court of appeals' conclusion that the statutory mandate that HSAs "seek the assistance" of private entities requires a displacement of the antitrust laws. The statute merely directs HSAs to seek private input into health planning decisions. It is clear that Congress intended to encourage communication between the public and HSAs, but there is no indication that Congress meant to sanction private restraints on competition. Parties may communicate with HSAs without abusing monopoly power or entering into unlawful agreements in restraint of trade, as alleged in the complaint in this case. Moreover, it is clear that the statute neither directs nor provides procedures to control private exclusionary conduct. To the contrary, under the statutory scheme, final implementation of a health plan rests with the HSA, not with private parties. And final determination whether a new hospital facility shall go into operation rests with the state regulatory agency. Since, in this case, there is not even a finding that Blue Cross's actions were taken to assist MAHSA in implementing its HSP, scrutiny of Blue Cross' action under the antitrust laws can hardly give rise to the "plain repugnancy" that is required to bestow immunity.

While seizing on the general statutory language discussed above, the court of appeals disregarded the only statutory language that specifically refers to

competition. 42 U.S.C. (Supp. III) 300k-2(a)(17) calls for the strengthening of competition in the health services industry when competition can serve the public interest. It is true that 42 U.S.C. (Supp. III) 300k-2(b)(1)-(3) indicates that the effectiveness of competition has been diminished to some extent by insurance payment procedures, and directs state health agencies and HSAs to allocate the supply of services when competition breaks down. But this same provision calls for promotion of competition when it can serve the public interest.[13] In sum, Congress has expressed a general policy in favor of competition; to the extent that competition is not effective in serving the public interest, Congress has required regulatory action by state agencies and HSAs—not private parties—to supplement competitive market forces.[14]

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[13] Sections 300k-2(a)(17) and 300k-2(b)(1)-(3) were added to NHPRDA in 1979. The legislative history shows that the endorsement of competition in 1979 was not a change in the underlying statutory design. There is no indication that the later Congress believed that its predecessor had rejected competition and the antitrust laws in the health care field. See S. Rep. No. 96-96, 96th Cong., 1st Sess. 8-9, 50, 52 (1979). The Senate Committee Report noted that:

> After four years experience with the law, Congress is now in a position to assess the strengths and deficiencies of the program, and to legislate the changes necessary to improve the process and fulfill the goals set forth in the original legislation.

Id. at 5. Such language hardly bespeaks an intent to reverse an earlier repudiation of competition and antitrust.

[14] The courts below pointed to congressional concern over increasing hospital costs and improper utilization of existing facilities (Pet. App. 11a-13a, 33a-34a), and Committee Reports calling for prevention of unnecessary duplication of resources and implementation of health plans with assistance

3. The court of appeals' decision also conflicts with the rationale of this Court's decision in *Silver* v. *New York Stock Exchange*, 373 U.S. 341 (1963). In *Silver*, this Court held that the failure of Congress to provide regulatory supervision over the challenged conduct indicated that there was not a sufficient conflict between the regulatory scheme and the antitrust laws to support an implied exemption. The Court's decision reflected the principle that in our society private parties may not arrogate to themselves the

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from the private sector (*ibid.*). These congressional materials, however, simply restate the provisions of the bill that were ultimately enacted. They add no different gloss to the statutory language.

The courts' reliance on Rep. Rogers' statements in debates preceding the 1979 amendments (Pet. App. 14a-15a, 34a-35a) is also misplaced. Even if directed at this type of case, Rep. Rogers' individual remarks would not meet the heavy burden of implying an antitrust exemption in the face of statutory language endorsing competition in the health services area. Nor are the remarks evidence of Congress's original intent in enacting NHPRDA for, as this Court frequently has held, opinions of individual legislators voiced after passage of legislation should be accorded little weight. *United States* v. *United Mine Workers*, 330 U.S. 258, 282 (1947); *Epstein* v. *Resor*, 296 F.Supp. 214, 216 (N.D. Cal. 1969), aff'd, 421 F.2d 930 (9th Cir.), cert. denied, 398 U.S. 965 (1970). Rep. Rogers' remarks fail to indicate a clear congressional intent to create a broad antitrust exemption for yet another reason: they are made to counter statements by others that NHPRDA did *not* bestow antitrust immunity sufficient to exempt all cooperative efforts of hospitals and HSAs. 124 Cong. Rec. H11962 (daily ed. Oct. 10, 1978). Finally, Rep, Rogers did not address the situation presented here—the unilateral action of Blue Cross in granting and withholding its own participating member contracts. Rather, he was addressing a situation in which private parties were participating in HSA activities, as contemplated by the NHPRDA.

authority to impose significant restraints on competition, even if they purport to serve the public interest. Such authority is public in nature: it is not entrusted to private hands. *Fashion Originators' Guild* v. *FTC*, 312 U.S. 457 (1941).[15] The court of appeals' decision fails to consider the extraordinary nature of its commitment of unsupervised public power to private hands. This Court's opinions require clear evidence that Congress intended such an exceptional result. No such evidence of congressional intent can be gleaned from this statute.

Indeed, the Act does not give even HSAs or state agencies unfettered authority to bar new entry into the health services field on grounds of "unnecessary" duplication. Decisions by HSAs to deny funding or refuse certificates of need are advisory only. 42 U.S.C. (Supp. III) 300*l*-2(e), (76 ed.) (f), (76 ed.) (h). They must be referred to state or federal bodies for final decision. 42 U.S.C. 300*l*-2(e)(2), (Supp. III) 300m-2(a)(4), (76 ed.) (5). At both the HSA and state agency levels, there are opportunities for notice and hearing before an application is denied (42 U.S.C. 300n-1(a), (Supp. III) (b)). And any final decision to deny an application is reviewable for arbitrariness, capriciousness, or failure to comply with the law. 42 U.S.C. (Supp. III) 300n-1(b)(12)(E). Thus, to the extent the Act does sanction decisionmaking by state agencies which might conflict with antitrust policies of free competition, the Act provides procedural safeguards and avenues of review to assure that the re-

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[15] When Congress envisions an economic process governed by business judgment rather than regulatory coercion, "courts must be hesitant to conclude that Congress intended to override the fundamental national policies embodied in the antitrust laws." *Otter Tail Power Co.* v. *United States*, *supra*, 410 U.S. at 374.

quired balancing of public interest considerations is effectuated in full compliance with statutory requirements.

In the present case, Blue Cross allegedly imposed an economic sanction on petitioner without the intermediation of any government body. MAHSA, whose policy Blue Cross purported to promote, lacked such power. It could only recommend that a state agency foreclose new entry. Under these circumstances, the court of appeals' decision immunizing private exclusionary action undercuts, rather than promotes, the manifest purposes of the statute.

4. The court of appeals' decision also conflicts with decisions of this Court holding that when Congress has explicitly immunized specified activities from the antitrust laws, that action "show[s] beyond question how far Congress intended that the * * * Act should operate to render the Sherman Act inapplicable. If Congress had desired to grant any further immunity, Congress doubtless would have said so." *United States* v. *Borden Co.*, 308 U.S. 188, 201 (1939); *Carnation Co.* v. *Pacific Westbound Conference*, 383 U.S. 213, 217 (1966); see also *California* v. *FPC*, *supra*, 369 U.S. at 485.

In NHPRDA, Congress expressly exempted from liability for damages "under any law of the United States or any state" a "health systems agency" and any "individual member of the governing body of a health systems agency" acting in performance of the agency's duties without gross negligence or malice. 42 U.S.C. (Supp. III) 300*l*-1(b)(4). See also 42 U.S.C. (Supp. III) 300m-3(d) (similar exemption from damage liability for members and employees of Statewide Health Coordinating Councils). These are carefully formulated and narrowly drawn exemptions. They are limited to specified entities and indi-

viduals. Moreover, the immunity itself is limited to damage actions; injunctive relief is still available. Thus, Congress has clearly declared the extent to which it intended to bestow immunity. Congress was, of course, aware of the fact that health providers and insurance companies like Blue Cross would participate with HSAs and their employees in health planning activities. But it chose not to clothe them with immunity. In view of the measured provision of immunity to certain persons, the absence of an express exemption for others like Blue Cross may not be attributed to congressional inadvertence. *Transamerica Mortgage Advisors, Inc.* v. *Lewis*, 444 U.S. 11, 19-20 (1979). The court of appeals' extension of immunity to private exclusionary activities in the health care field that arguably foster congressional goals is thus contrary to the statute itself, as well as to the decisions of this Court.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

WADE H. MCCREE, JR.
Solicitor General

SANFORD M. LITVACK
Assistant Attorney General

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Attorneys

DECEMBER 1980

ATTACHMENT A

[SEAL]

DEPARTMENT OF JUSTICE

FOR IMMEDIATE RELEASE AT
THURSDAY, MAY 8, 1980 202-633-2014

The Department of Justice today announced it had sent a business review letter stating the Antitrust Division's enforcement intentions with respect to certain proposed activities of Central Virginia Health Systems Agency (CVHSA).

The Department's position was stated in a May 6 letter by Sanford M. Litvack, Assistant Attorney General in charge of the Antitrust Division, to William G. Kopit, attorney for CVHSA.

The agency is a publicly financed, private, nonprofit corporation, with headquarters in Richmond, Virginia. It is one of about 200 health systems agencies designated by the United States Department of Health Education and Welfare pursuant to the National Health Planning and Resources Development Act of 1974.

The activities proposed by CVHSA included conduct that could involve concerted action by local providers affecting the supply and price of health services.

The business review raised the question of the extent to which the Act creates creates an implied antitrust immunity for the providers and health systems agencies that undertake such conduct.

The Department's letter said that certain of the activities proposed by CVHSA appear to be clearly contemplated by the relevant statutes, such as:

—Reviewing applications for certificates of need for new institutional health services;

—Recommending to the appropriate agency of the Commonwealth of Virginia whether such certificates should be granted;

—Reviewing applications for federal grants;

—Making recommendations to HEW on such grants;

—Reviewing existing institutional health services;

—Advising state agencies of the appropriateness of such services.

The Department has no intention to challenge such activities so long as they correspond to the statutory scheme.

On the other hand, the Department does not believe that the Health Planning Act creates a complete exemption for all efforts by health systems agencies and private parties working with them to implement their plans.

For example, the Department believes that agreements among competing hospitals limiting the number of patients they could serve or the kinds of service they could offer are probably not exempt from the antitrust laws in the absence of conscious and explicit authorization by the State.

The letter said that the Department will formulate enforcement intentions on specific implementation activities only upon detailed assessment of the conduct in question.

In doing so, the Department will consider a variety of factors, including the relationship of the conduct to goals established by Congress, the degree to which competition would properly allocate resources if given the opportunity, whether providers or third-party

payers will act in concert and whether coercive measures are used.

The Department said it was unable to state its enforcement intentions with respect to the health system plan and implementation plan activities proposed by CVHSA because the proposed conduct was too general and its effects too unpredictable.

The Department's letter noted with approval that CVHSA had deleted from its plan a statement that it would encourage certain hospitals to explore the feasibility of cooperative assessments that would result in joint action to adjust the number of beds, physicians and allied health manpower.

Under the Department's Business Review Procedure an organization may submit a proposed action to the Antitrust Division and receive a statement as to whether the Division would challenge that action under the antitrust laws.

A file containing the business review request and the Department's response will be made available to the public immediately and may be examined in the Legal Procedure Unit, Antitrust Division, Room 7416, Department of Justice, Washington, DC 20530. After a 30-day waiting period, the documents supporting the business review will be added to the above file.

* * * *

UNITED STATES DEPARTMENT OF JUSTICE

Washington, D.C. 20530

[SEAL]

ASSISTANT ATTORNEY GENERAL
ANTITRUST DIVISION

6 May 1980

William G. Kopit, Esquire
Epstein, Becker, Borsody & Green
1900 M Street, N.W.
Washington, D.C. 20036

Dear Mr. Kopit:

This responds to your letter of January 25, 1979, requesting a statement of the Department's present enforcement intentions, through the Antitrust Division's Business Review Procedure, concerning proposed activities of the Central Virginia Health Systems Agency [CVHSA]. On May 1, 1979 you submitted additional material in response to our request for more information.

CVHSA is a publicly financed, private, nonprofit corporation which performs health planning functions pursuant to the National Health Planning and Resources Development Act of 1974, Pub. L. 93-641, 42 U.S.C. § 300k *et seq.* [the Act]. While CVHSA engages in health planning and other advisory functions, it is not a governmental agency of either the United States or the Commonwealth of Virginia. It is one of about 200 Health Systems Agencies [HSAs] which have been fully designated by the United States Department of Health, Education and

Welfare [HEW] under the Act. The activities proposed by CVHSA include conduct that may involve concerted action by local providers affecting the supply and price of health services. This raises the question of the extent to which the Act creates an implied antitrust immunity for the providers and HSAs that undertake such conduct.

In accordance with the Act and guidelines and regulations issued thereunder, CVHSA has published a Health Systems Plan and an Annual Implementation Plan for the Central Virginia Health Service Area. On the basis of these Plans, CVHSA proposes to undertake four activities. It will:

(1) review applications for certificates of need for new institutional health services, and recommend to the appropriate agency of the Commonwealth of Virginia whether such certificates should be granted;

(2) review applications for federal grants for the development, expansion, or support of health resources, and recommend to HEW whether such grants should be approved;

(3) review existing institutional health services and advise the proper state agency about the appropriateness of such services; and

(4) seek to implement its Health Systems Plan and Annual Implementation Plan with the assistance of individuals and public and private entities.

In developing its plans, and in performing these four functions, CVHSA has stated that it will comply with all requirements of the Act and regulations promulgated thereunder. It will encourage providers

and consumers of health care services to participate in its activities by inviting them to testify at public hearings and submit written comments.

Decisions by the Department of Justice as to whether to initiate antitrust enforcement actions necessarily are based upon analysis of the factual and legal context of the proposed conduct. The role of competition in affected industries, the achievement of the ultimate goals which competition and the antitrust laws serve, and relevant statutory schemes established at the state and federal levels all must be taken into account in judgments regarding whether certain conduct unreasonably restrains trade or is in any event authorized or directed by other laws. These judgments are particularly difficult in the health planning area due to the peculiar economic incentives created by the existence of third-party payers and the comprehensive statutory and regulatory environment.

Certain of the activities proposed by CVHSA appear to be clearly contemplated by relevant statutes. Thus, we have no present intention to bring antitrust enforcement actions challenging the first three activities proposed by CVHSA—certificate of need review, federal grant review, and appropriateness review. The Act specifically requires HSAs to advise governmental agencies on these subjects. 42 U.S.C. §§ 3001-2(e), 3001-2(f), 3001-2(g). Our statement of enforcement intentions is, of course, premised on the assumption that the activities of CVHSA will in all respects correspond to the statutory scheme.

We are unable, however, to state specific enforcement intentions with respect to the Plan implementation activities described in (4) above. The requisite competitive analysis cannot be undertaken because

the proposed conduct is too general and its effects too unpredictable. This uncertain factual context, the ambiguous language of the Act, and the lack of any reference to the antitrust laws makes a responsible enforcement decision impossible.

Also, unlike the other three functions described in your submission, the Plan implementation activities cover a broad spectrum of conduct not necessarily authorized or even contemplated by the Act. We cannot imply antitrust immunity for such activities. For example, we note that the "Annual Implementation Plan, 1978-1979" originally submitted to us contained a statement that:

> Hospitals in Planning Districts 13, 14, 15, and 19 offering obstetric services will be encouraged by the Central Virginia Health Systems to explore the feasibility of cooperative assessments that will result in joint action to adjust the number of beds, physicians and allied health manpower, and the division of services in a manner that will best serve the needs of the people of HSA IV.

As we have advised you, we believe that agreements among competing hospitals limiting the number of patients they could serve or the kinds of services they could offer in the absence of conscious and explicit authorization and supervision by the State are probably not contemplated by the Act nor exempt from the application of federal antitrust laws. The following statement in your letter to the Antitrust Division of May 1, 1979 appears to recognize this and is reassuring:

> . . . No implementation activities undertaken by the Agency as a result of any Agency recom-

> mendation made pursuant to any review activity described above, including actions designed to encourage voluntary action based on the results of an appropriateness review, will involve any combined or concerted activity between the Agency, or its personnel or agents, and two or more medical care institutions, either directly or through any organization or organizations representing groups of such institutions.

In essence, we do not believe that the Health Planning Act creates a complete antitrust exemption for all efforts by HSAs, and private parties working with HSAs, to implement health plans. An antitrust exemption protecting all activities which arguably furthered the general statutory goals is not, in our view, justified. The legislative history of the Act reveals no congressional intent to restrict the operation of the antitrust laws to such an extent. Moreover, that interpretation would clearly conflict with the well-established principle that implied repeal of the antitrust laws is disfavored and that antitrust exemptions should be construed narrowly.

Thus, we would formulate enforcement intentions with respect to specific implementation activities only upon assessment in detail of the conduct in question, the specific circumstances in which it occurs, its relationship to the goals established for health planning by Congress and to the specific objectives of relevant plans, whether the conduct is necessary to achieve those goals and objectives, the degree to which competition would properly allocate resources if given the opportunity, and the availability of less anticompetitive alternatives. Relevant considerations would also include the extent to which plans are sufficiently detailed to assure that what is being

"implemented" has in fact been approved under relevant statutes; whether providers or third-party payers will act in concert, rather than unilaterally; and whether coercive measures are used.

As you know, there is considerable debate as to the relative merit of various approaches to the important problem of hospital cost containment, and the role that competition may play in those approaches. As knowledge grows, and laws and policies are formulated, application of the antitrust laws should become more definitive. Meanwhile, in exercising our prosecutorial discretion, we are mindful that an underlying purpose of both the antitrust laws and the Act is to promote a proper allocation of economic resources in light of congressionally stated goals.

Our statement herein is made in accordance with the Department's business review procedure, 28 C.F.R. 50.6. Pursuant to its terms, your business review request and this letter will be available to the public immediately and your supporting data will be made available publicly within 30 days of the date of this letter.

Sincerely yours,

/s/ Sanford M. Litvack
Assistant Attorney General
Antitrust Division

ATTACHMENT B

DEPARTMENT OF JUSTICE

[SEAL]

FOR IMMEDIATE RELEASE AT
FRIDAY, AUGUST 29, 1980 202-633-2014

The Department of Justice announced today that it could not rule out antitrust enforcement action against a proposed agreement between the Westlake Health Campus Association, Westlake, Ohio, and Lakewood Hospital, Lakewood, Ohio. The agreement would prevent the Association from offering specified health care services at its hospital, now under construction in Westlake.

The Department's position was contained in a business review letter signed by Sanford M. Litvack, Assistant Attorney General in charge of the Antitrust Division, issued August 27.

The Department's intentions were requested concerning the proposed agreement—part of an overall agreement in settlement of lawsuits between the Hospital and the Association.

The proposed agreement would provide that for a 10-year period through 1988 the new facility would not offer cardiac surgery, major vascular surgery, microscopic neurosurgery, joint replacement, microscopic ENT procedures, microscopic opthalmology procedures, cardiac catheterization laboratory services or CAT scanner services unless such services became customary for a 200-bed acute care hospital.

The Department's letter pointed out that this agreement could reduce competition between competing hospitals. Moreover, the agreement is not exempted

from the operation of the antitrust laws by virtue of any state or federal legislation.

The letter also stated, "Moreover, the agreement may limit the effectiveness of the state's regulatory program, since the state may be denied the opportunity to consider a Certificate of Need application from an otherwise qualified applicant."

Under the Department's business review Procedure, and organization may submit a proposed action to the Antitrust Division and receive a statement as to whether the Division would challenge that action under the antitrust laws.

A file containing the business review request and the Department's response will be made available to the public immediately and may be examined in the Legal Procedure Unit, Antitrust Division, Room 7416, Department of Justice, Washington, D.C. 20530. After a 30-day waiting period, the documents supporting the business review will be added to the above file.

UNITED STATES DEPARTMENT OF JUSTICE

Washington, D.C. 20530

[SEAL]

Assistant Attorney General
Antitrust Division

SML:JWP

60-423-134

August 27, 1980

Paul A. Schraff, Esquire
Ford, Whitney, Crump & Schulz
1500 Williamson Building
Cleveland, Ohio 44114

Dear Mr. Schraff:

This responds to your letter of October 9, 1979, requesting a statement of the Department's present enforcement intentions, through the Antitrust Division's Business Review Procedure, concerning a proposed agreement between the Westlake Health Campus Association (the Association) and Lakewood Hospital.

The Association will operate a 200-bed acute care general hospital, now being constructed, in Westlake, Ohio. The association was formed by St. John Hospital, a 323-bed acute care general hospital, and West Shore Health Center, an Ohio non-profit corporation. West Shore Health Center was formed by Fairview General Hospital, a 457-bed acute care general hospital, and Cleveland Osteopathic Hospital, d.b.a. Bay view Hospital, a 116-bed acute care general hospital. Lakewood Hospital is a 378-bed acute care general hospital operated by the City of Lakewood, an Ohio municipal corporation. All four

hospitals are located in the western portion of Cuyahoga County, Ohio, and have overlapping service areas.

On January 5, 1979, Lakewood Hospital filed a lawsuit against the Association in the Court of Common Pleas, Cuyahoga County, Ohio, seeking to enjoin construction of the Association's proposed hospital. Lakewood Hospital alleged, among other things, that the construction and operation of the hospital would result in a decrease of occupany in Lakewood. In anticipation of this lawsuit, the Association had filed an action for declaratory judgment on January 4, 1979.

These lawsuits, which had been consolidated, were settled on January 26, 1976. The settlement included a proposed agreement that the Association would not provide any of eight specified services * until after December 31, 1988, unless the offering of any such service became customary for a 200-bed acute care hospital. The agreement will go into effect only if the Department of Justice states that it has no present intention to take any enforcement action with respect to the agreement. It is our understanding that the Association could not offer these services in any event without obtaining a Certificate of Need pursuant to Chapter 3702 of Ohio Code.

Agreements between competitors as to the products or services that each will offer are prohibited by the antitrust laws because of their plainly anticompetitive purpose and effect. State and federal

---

* Cardiac surgery, major vascular surgery, microscopic neurosurgery, joint replacement, microscopic ENT procedures, microscopic ophthalmology procedures, cardiac catheterization laboratory services and CAT scanner.

regulatory programs reflect a legislative judgment that if competition is to be restrained, it should be restrained by the appropriate regulatory agencies, and not by private agreements. The agreement has not been authorized or required by any regulatory agency and is not subject to governmental supervision. It has not been addressed by the health systems agency plan and has not been authorized or required by the health systems agency or the state health planning and development agency. Moreover, the agreement may limit the effectiveness of the state's regulatory program, since the state may be denied the opportunity to consider a Certificate of Need application from an otherwise qualified applicant. These considerations also preclude the application of any implied antitrust exemption that may arise from the National Health Planning and Resources Development Act, 42 U.S.C. § 300k *et seq.*, from which the state regulatory scheme is derived. Accordingly, the Department cannot state an intention not to sue to enjoin the proposed agreement.

Our statement herein is made in accordance with the Departments business review procedure, 28 C.F.R. 50.6. Pursuant to its terms, your business review request and this letter will be available to the public immediately. Your supporting data will be made available publicly within 30 days of the date of this letter unless you request that any part of the material be withheld in accordance with Paragraph 10 (c) of the Business Review Procedure.

Sincerely yours,

/s/ Sanford M. Litvack
SANFORD M. LITVACK
Assistant Attorney General
Antitrust Division

October 9, 1979

Assistant Attorney General
Antitrust Division
Department of Justice
Washington, D.C. 20530

Re: *Westlake Health Campus*

Dear Sir:

This is to request review by the Antitrust Division of the Justice Department, of the enclosed proposed Agreement between Westlake Health Campus Association (the Association) and the City of Lakewood (the Agreement) (see enclosed Item B). The undersigned submit this request pursuant to authorization by their respective clients, who are parties to the Agreement.

The Agreement, which has not yet been executed, results from the settlement of litigation brought by the City of Lakewood challenging the new hospital which the Association proposed to build in western Cuyahoga County, Ohio. As a condition of the settlement, both the Antitrust Division and the Ohio Attorney General must give a favorable business review to the Agreement, whereby the Association would agree not to provide certain services and facilities in its new hospital. The City of Lakewood owns and operates Lakewood Hospital. The Association, an Ohio non-profit corporation, is building a new hospital and is comprised of existing hospitals (see enclosed Item 1, pages vii and viii for overview of corporate structure). Service areas of the hospitals overlap. The antitrust implications of the Agreement necessitate this request for review.

The following documents are submitted herewith:

Item A—Proposed Agreement between Lakewood (Lakewood Hospital) and the Association;

Item B—Letter Agreement dated January 26, 1979 from the Association to the City of Lakewood;

Item C—Statement of Relevant Data and Background Information (the Statement);

Items 1 through 37—Operative documents and other exhibits (see enclosed table of contents).

Please note that all operative documents referred to in the Statement are included herein. All understandings between the parties are embodied in the enclosed documents and there are no collateral oral understandings.

If any additional information is required, please direct your request jointly to the undersigned.

Very truly yours,

/s/ Paul A. Schraff
PAUL A. SCHRAFF
Ford, Whitney, Crump & Schultz
Counsel for Lakewood Hospital

/s/ James D. Knotter, Jr.
JAMES D. KNOTTER, JR.
Hahn, Loeser, Freedheim,
Dean & Wellman
Counsel for St. John Hospital

/s/ Robert E. Glaser
ROBERT E. GLASER
Arter & Hadden
Counsel for Westlake Health
Campus Association,
West Shore Health Center and
Bay View Hospital

ATTACHMENT C

[SEAL]

DEPARTMENT OF JUSTICE

FOR IMMEDIATE RELEASE AT
TUESDAY, JUNE 13, 1978 202-739-2014

The Department of Justice today declined to say whether it would take antitrust action on a proposed "Voluntary Cost Containment Program" sponsored by the American Hospital Association, the American Medical Association, and the Federation of American Hospitals.

Hugh P. Morrison, Jr., Acting Assistant Attorney General in charge of the Antitrust Division, said the Department's position was in a business review letter issued June 12.

Under the proposed program, state hospital and medical societies would establish goals for hospital cost increases and would attempt to persuade hospitals to hold cost increases below the specified amount.

The Department noted that the national sponsors of the program would not control the goals adopted or the procedures used to persuade hospitals.

The letter said that such a program, if adopted in other industries, would violate the antitrust laws, because it would lessen the independence of individual firms in making business decisions.

The applicants argued that there were significant differences between the hospital service industry and other industries and that the program would not have the predictable anticompetitive consequences of similar activity in other industries.

The Department concluded that, to reach a definitive conclusion, it would have to speculate about the

competitive effects of uncertain conduct in a very unusual market.

Under the Department's Business Review Procedure a firm or organization may submit a proposed action to the Antitrust Division and receive a statement as to whether the Division would challenge that action under the federal antitrust laws.

After a 30-day waiting period, a file containing the Business Review request, the supporting documents, and the Department's response will be made available to the public and may be examined in the Legal Procedure Unit of the Antitrust Division, Room 7416, Department of Justice, Washington, D.C. 20530.

UNITED STATES DEPARTMENT OF JUSTICE
Washington, D.C. 20530

[SEAL]

Assistant Attorney General
Antitrust Division

[Jun. 12, 1978]

Richard J. Wertheimer, Esq.
Arnold & Porter
1229 Nineteenth Street, N.W.
Washington, D.C. 20036

Dear Mr. Wertheimer:

This is in response to your February 2, 1978 letter requesting a statement of the Department's present enforcement intentions, pursuant to the Antitrust Division's Business Review Procedure, with regard to a proposed Voluntary Hospital Cost Containment Program sponsored by the American Hospital Association, the American Medical Association and the Federation of American Hospitals.

As indicated in your letter of February 2, the Program's National Steering Committee has adopted national objectives of (1) a 2% reduction in the rate of increase of non-federal, short-term hospital expenditures, for each of the next two years, (2) no net increase in the total stock of hospital beds as of December 31, 1977, and (3) a reduction, over the next two years, on total new capital investment to 80% of the annual price adjusted average of such investment for the period 1975-1977.

In order to achieve these goals, the Steering Committee has asked the hospital association and medical society of each state to form state cost containment committees. The state committees will be assisted by full-time professional staffs, and committee expenses will be shared by the state hospital association and medical society.

Each state committee will adopt specific numerical goals for containing hospital expenditures within its state. The committee will also adopt screening guidelines for identifying hospitals which may require special attention.

After developing these goals and guidelines, state committees will adopt one or more of the following programs. Under a "Certification Program," the state committee would certify, as participants in the cost containment program, hospitals which (1) submit a resolution endorsing the state program and its objectives, (2) review current operating and capital expenditure budgets to determine if the rate of increase can be reduced, and (3) submit a written report specifying how the guidelines are being met, and explaining any failure to meet the guidelines. The state committee may identify hospitals which do not participate in the program, but no other action will be taken against non-participating hospitals.

Under a "Technical Assistance Program," hospitals will be offered a broad range of technical assistance, generally of a consulting nature, to help them evaluate their policies, improve their management operations, and examine and modify their organizational goals and objectives.

Under a "Review Program," participating hospitals which fail to meet state guidelines may undergo formal review and be asked to submit written justifications. If the state committee determines that

these justifications are inadequate, a public or private hearing may be held, at which the hospital will be allowed to present witnesses and additional information. The state committee will then issue in writing, and make available to the public, its findings and conclusions as to whether the hospital's justifications are reasonable.

In addition, the state committees will work closely with the state and local health planning agencies. The committees will assist those agencies in assessing the particular health care needs of the state, and ask that the committee's goals be considered in the review of individual hospital capital investment proposals.

You have represented that participation in this program is entirely voluntary. No hospital will be compelled to participate, and the state committees will take no action against non-participating hospitals, beyond publicizing the fact of non-participation. In addition, however, you have indicated that each state committee will make its own decisions and adopt its own procedures, and the National Steering Committee will have no authority to compel adherence by individual state committees or their members to the goals and procedures it set forth.

As you are aware, joint action by competitors which lessens the independence of individual firms regarding the price, quantity, or quality of the goods and services they purchase or sell raises serious antitrust issues. In fact, as you recognize, the conduct proposed here would almost surely be considered an antitrust violation in many other industry contexts. Nevertheless, you have argued that the application of this fundamental antitrust principle is not dispositive here; that because of the peculiar

structure of the hospital service market, the joint activity contemplated by this program may not have the predictable anticompetitive consequences of similar activity in other industries.

There may well be significant differences between the hospital service industry and other industries that affect the competitive potential of particular conduct. However, the necessarily generalized description of the program and the way in which it will be carried out, the difficulty in predicting its actual impact, and the tentative nature of our present understanding of this complex industry preclude a definitive analysis of the proposal. To attempt such an analysis would require undue speculation about the possible competitive effects of uncertain conduct in a very unusual market. Accordingly, we must decline your request for a statement of our enforcement intentions with regard to this program.

Our statement herein is made in accordance with the Department's business review procedure, 28 C.F.R. 50.6. Pursuant to its terms, your business review request and this letter will be available to the public immediately and your supporting data will be made available publicly within thirty days of the date of this letter.

Sincerely yours,

/s/ Hugh P. Morrison, Jr.
HUGH P. MORRISON, JR.
Acting Assistant
Attorney General
Antitrust Division

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No. 80-802

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER,
Petitioner,

v.

BLUE CROSS OF KANSAS CITY AND BLUE CROSS ASSOCIATION,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

BRIEF FOR PETITIONER

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QUESTION PRESENTED

The National Health Planning and Resources Development Act of 1974, as amended, directs a Health Systems Agency (in this case a private Missouri corporation engaged in health planning activities) to "seek, to the extent practicable, to implement its HSP [Health Systems Plan] and AIP [Annual Implementation Plan] with the assistance of individuals and public and private entities in its health service area."

The question presented is whether this general statutory language is so inconsistent with the antitrust laws that it should be construed to grant an exemption from those laws for a concerted refusal to deal by Blue Cross of Kansas City, Blue Cross Association, and other persons, where there was no involvement by a state or federal agency, where there was no state or federal mandate or supervision of the parties or conduct involved, and where the federal statute did not expressly immunize the boycott.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	iv
OPINIONS BELOW	1
JURISDICTION	1
STATUTORY PROVISIONS INVOLVED	2
STATEMENT	2
Proceedings Below	5
SUMMARY OF ARGUMENT	8
ARGUMENT	10
I. Introductory Statement	10
II. Under The Guidelines Established By This Court, There Is No Basis Here For Finding An Implied Repeal Of the Sherman Act	14
A. Neither the language nor the legislative history of the Planning Act gives any "clear and manifest" indication that Congress intended implied repeal	17
B. The Planning Act and the antitrust laws are not irreconcilable	22
1. The Planning Act neither requires nor authorizes the conduct at issue here	23
2. Antitrust immunity for voluntary, private, anticompetitive conduct is not necessary to make the Planning Act work	34
CONCLUSION	42

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CASES: Page

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Page

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National Society of Professional Engineers v. *United States*, 435 U.S. 679 12

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Parker v. *Brown*, 317 U.S. 341 13

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Silver v. *New York Stock Exchange*, 373 U.S. 341 .... 9, 16, 22, 30, 33, 35, 36, 39, 41

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Table of Authorities Continued

Page

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15 U.S.C. § 1 .....2, 6, 35

15 U.S.C. § 2 ..... 2, 6

15 U.S.C. § 1012 ..... 6, 13

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42 U.S.C. § 300k(b) 23

42 U.S.C. § 300k-1 24

42 U.S.C. § 300k-3 24

42 U.S.C. § 300*l* 24

42 U.S.C. § 300*l*(b)(1) 23

42 U.S.C. § 300*l*-1 ..... 4, 23

42 U.S.C. § 300*l*-1(b)(1)(A)-(C) 4

42 U.S.C. § 300*l*-2(b) 23

42 U.S.C. § 300*l*-2(c)(1) 2, 6, 7, 8, 20, 25, 26

42 U.S.C. § 300*l*-2(f) 4, 23

42 U.S.C. § 300*l*-2(g)(1) and (2) 23

Table of Authorities Continued

Page

42 U.S.C. §§ 300*l*-4 24

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42 U.S.C. § 300m 4, 23, 24

42 U.S.C. § 300m(d) 24

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No. 80-802

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

NATIONAL GERIMEDICAL HOSPITAL
AND GERONTOLOGY CENTER,
Petitioner,

v.

BLUE CROSS OF KANSAS CITY AND
BLUE CROSS ASSOCIATION,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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BRIEF FOR PETITIONER

OPINIONS BELOW

The Opinion of the United States Court of Appeals for the Eighth Circuit is reported at 628 F.2d 1050, and is set out in the Joint Appendix at pp. 199a-213a. The Order of the District Court for the Western District of Missouri is reported at 479 F. Supp. 1012, and is set out in the Joint Appendix at pp. 171a-198a.

JURISDICTION

The judgment of the United States Court of Appeals for the Eighth Circuit was entered on July 22, 1980. (J.A. at 215a.) A petition for rehearing and rehearing en banc was denied on August 22, 1980. (J.A. at 217a.) The Petition

for Certiorari was filed on November 18, 1980, and was granted January 26, 1981.

The jurisdiction of this Court rests on 28 U.S.C. § 1254 (1).

STATUTORY PROVISIONS INVOLVED

Section 1 of the Sherman Act, 15 U.S.C. § 1, provides in pertinent part:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.

Section 2 of the Sherman Act, 15 U.S.C. § 2, provides in pertinent part:

> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony.

Section 300*l*-2(c)(1) of the National Health Planning and Resources Development Act, as amended, as it appears in 42 U.S.C., provides:

> A health systems agency shall implement its HSP [Health Systems Plan] and AIP [Annual Implementation Plan], and in implementing the plans it shall perform at least the following functions:
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> > (1) The agency shall seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area.

STATEMENT

This case involves the boycott of a new entrant nonprofit hospital by private health care reimbursement organiza-

tions. The facts before the court below may be summarized as follows:[1]

The petitioner, National Gerimedical, is a fully accredited, general acute care community hospital which opened on October 16, 1978. (J.A. at 6a; D.R. Supp. at 15.) It has been continuously licensed by the Missouri Division of Health since September, 1977, and has been fully certified as a Medicare provider by the Department of Health, Education and Welfare (now Health and Human Services) since its opening. (D.R. Supp. at 14.) One of the respondents, Blue Cross of Kansas City ("Blue Cross"), is a Missouri Health Services Corporation which markets and sells prepaid health reimbursement plans to the public, and contracts with health care providers to administer the plans. (J.A. at 7a; 479 F. Supp. at 1015, J.A. at 174a.) The other respondent, Blue Cross Association ("BCA"), is a national organization to which local Blue Cross plans, including Blue Cross, belong. (J.A. at 7a; D.R. at 198.)

Prior to opening in 1978, petitioner sought to enter into a participating hospital agreement with Blue Cross. This was important to National Gerimedical's economic viability: participating hospitals receive directly one hundred percent reimbursement for covered hospital services rendered to individual Blue Cross subscribers; reimbursement for covered services at nonparticipating hospitals is made, not to the hospital, but directly to the subscriber, and for no more than eighty percent of the cost of the services. (J.A. at 9a; 479 F. Supp. at 1015-16, J.A. at 174a.) It was feared (and rightly so) that lack of participating hospital status would discourage Blue Cross subscribers from seeking services at National Gerimedical, thereby placing it at a substantial competitive disadvantage. (J.A. at 15a-

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[1] Citations to the record below are to the Designated Record on Appeal, cited "D.R."; to the Supplementary Designated Record on Appeal, cited "D.R. Supp."; and to the Joint Appendix, cited "J.A."

16a, 168a; D.R. Supp. at 19.) Blue Cross' individual members account for approximately one-fourth of all area hospital admissions, and all licensed general acute care community hospitals in Blue Cross' service area except National Gerimedical have Blue Cross participating contracts. (J.A. at 8a-9a; D.R. at 261; 479 F. Supp. at 1015, J.A. at 174a.)

On March 21, 1978, Blue Cross refused to enter into a participating hospital contract with National Gerimedical solely because it had not obtained a "finding of need" from the Mid-America Health Systems Agency ("MAHSA"). (J.A. at 10a; 479 F. Supp. at 1016, J.A. at 175a.) MAHSA is a private, not-for-profit Missouri corporation engaged in voluntary health planning activities. It is funded as a health systems agency within the terms of the National Health Planning and Resources Development Act of 1974 ("Planning Act"), 42 U.S.C. §§ 300k *et seq.*[2] (J.A. at 7a; 479 F. Supp. at 1016, J.A. at 175a.) Under the Planning Act, an HSA's sole function with respect to new hospital construction is to advise state health agencies. 42 U.S.C. 300*l*-2(f).

Since no federal or Missouri law required National Gerimedical to seek or secure "need" review,[3] and since MAHSA

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[2] The Planning Act established three types of health planning agencies. (*See* 42 U.S.C. §§ 300*l*-1, 300m, 300m-3.) The only type directly relevant here, Health Systems Agencies (HSAs), may be nonprofit, private corporations, public regional planning bodies, or single units of local governments. 42 U.S.C. § 300*l*-1(b)(1)(A)-(C). MAHSA, which is a private corporation, was conditionally designated by the Secretary of the Department of Health, Education, and Welfare (now the Department of Health and Human Services ("DHHS")) as one of 205 regional health systems agencies under the Planning Act on April 12, 1976. (D.R. at 18.)

[3] At the time petitioner's complaint was filed and at all pertinent times, Missouri had no compulsory certificate of need program, nor had it designated a State Health Planning and Development Agency in accordance with 42 U.S.C. § 300m. (J.A. at 139a-140a; 628 F.2d at 1054, J.A. at 205a.) Both are prerequisites to any

had publicly declared that it would disapprove the addition of any additional acute care hospital beds (J.A. at 11a; 479 F. Supp. at 1016, J.A. at 175a.), National Gerimedical did not seek review by MAHSA. On that sole basis, Blue Cross denied petitioner's request for participating hospital status. (J.A. at 10a, 169a-170a; 479 F. Supp. at 1016, J.A. at 175a.) The Blue Cross "need" requirement was imposed by Blue Cross pursuant to BCA policy guidelines. (J.A. at 10a-11a, 153a, 164a-165a.)

Proceedings Below

On May 23, 1978, National Gerimedical filed an antitrust complaint in the United States District Court for the Western District of Missouri against Blue Cross and BCA, in

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requirement under the Planning Act to seek "need" review by the relevant HSA. *See* 42 U.S.C. § 300m-2(a)(4)(A). In August, 1979, Missouri enacted a Certificate of Need Law (Mo. Ann. Stat. §§ 197.300 *et seq.* (Vernon Supp. 1980)), which, by its terms, became fully effective in October, 1980. Under the provisions of that law, petitioner was deemed to have received a certificate of need.

In addition, Missouri was not a participant in the health care capital expenditure review program under section 1122 of the Social Security Act (42 U.S.C. § 1320a-1), pursuant to which a state may voluntarily enter into a contract with DHHS by which it designates an agency of the state to review the need for new capital health care expenditures. Under that program, health care facilities may not be reimbursed under the Medicare, Medicaid, or maternal and child health programs for depreciation, interest, or return on equity capital or other expenses relating to capital expenditures determined by the designated state planning agency to be unnecessary. On June 30, 1976, Missouri refused to renew its section 1122 contract. (J.A. at 139a; 628 F.2d at 1053, J.A. at 203a.) Thus, no section 1122 program was in effect in Missouri at any time here pertinent.

Blue Cross' "requirement" of MAHSA approval, therefore, was not mandated by any federal or state legislation, and in fact was flatly inconsistent with the public policies established by the state legislature of Missouri.

which it named MAHSA and others as non-defendant co-conspirators.[4] The complaint alleged that a collective refusal to deal by Blue Cross and BCA, acting in concert with various co-conspirators, constituted a violation of section 1 of the Sherman Act, and that Blue Cross' actions, standing alone, violated section 2 of that Act. (J.A. at 10a-14a; 479 F. Supp. at 1014, J.A. at 171a-172a.)

On July 14, 1978, BCA and Blue Cross moved to dismiss the complaint on a variety of grounds. (J.A. at 19a-23a; 479 F. Supp. 1014, J.A. at 172a.) On November 2, 1979, the district court, treating the motion as one for summary judgment, held that the complaint stated a cause of action under section 1; that the requisite effect on interstate commerce had been properly alleged; and that the conduct involved was not exempt from antitrust scrutiny under section 2 of the McCarran-Ferguson Act (15 U.S.C. § 1012), as that exemption was construed by this Court during the pendency of this action in *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205. (479 F. Supp. at 1016-19, 1024-26; J.A. at 176-181a, 192a-196a.) Nevertheless, the district court granted summary judgment for defendants, finding that the Planning Act [5] created an implied "blanket exemption" from the antitrust laws for any and all voluntary private action "taken pursuant to the Act and clearly within the scope of the Act." (479 F. Supp. at 1021, 1024; J.A. at 186a, 192a.)

The district court relied primarily on section 300*l*-2(c)(1) of the Act, which merely directs HSAs to seek the assistance of individuals and public and private entities in im-

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[4] The other named co-conspirators were all either individuals who served simultaneously as members of the Board of Trustees of Blue Cross and the Board of Directors of MAHSA, employees of Blue Cross serving as members of the MAHSA Board of Directors, or individuals employed by competitors of National Gerimedical who served on the Blue Cross Board of Directors.

[5] 42 U.S.C. §§ 300k *et seq.*

plementing their health service plans,[6] and on the MAHSA plan itself, which states as objectives various cost containment goals. On this tenuous basis, the court concluded that "the certificate of need requirement voluntarily adopted by Blue Cross of Kansas City seems to be authorized by the Act as well as the implementation plan of MAHSA." (479 F. Supp. at 1021, J.A. at 186a.) The court then found an irreconcilable conflict between the antitrust laws and the Planning Act which required a "blanket" exemption from the antitrust laws for any and all private actions ostensibly taken to further the public policy goals of the Act. (479 F. Supp. at 1021, J.A. at 186a.)[7]

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[6] Section 300*l*-2(c)(1) reads as follows:

> A health systems agency shall implement its HSP [Health Systems Plan] and AIP [Annual Implementation Plan], and in implementing the plans it shall perform at least the following functions:
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> (1) The agency shall seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area.

[7] The court reasoned:

In determining if an exemption to the antitrust laws can be implied, courts have distinguished two types of exemptions—specific and blanket. A specific repeal of the antitrust laws implies an exemption only for particular conduct or activity. An exemption for an entire legislative scheme would be a blanket exemption. Courts that have upheld claims of implied repeal have normally limited this repeal to the specific conduct challenged in that particular case; *however, in the circumstances of this case defendant's claim is that the entire concept of the National Health Planning and Resource Development Act presupposes nonapplication of the antitrust laws so that any activity authorized and within the scope of that Act is free from antitrust challenges.* The proper issue in this case then is whether there is a plain repugnancy between the scope of the National Health Care Planning and Development Act and the antitrust laws. Another formulation of this same test of somewhat easier application is whether an exemption to the anti-

The Court of Appeals, noting that the district court's finding of implied immunity for Blue Cross rested primarily on section 300*l*-2(c)(1) of the Act (628 F.2d at 1052, J.A. at 202a), affirmed the decision in an opinion which closely adhered to the district court's analysis. It concluded that "the Act and regulatory scheme clearly call for the action which has now become the basis of an antitrust claim"; the Court of Appeals thus agreed with the district court that there was a "clear repugnancy between the Act and the antitrust laws." (628 F.2d at 1055, J.A. at 209a.) Finally, it adopted the district court's analysis and conclusion that it was the "intent of Congress to immunize this type of voluntary action from the antitrust laws." (628 F.2d at 1056, J.A. at 209a.)

SUMMARY OF ARGUMENT

The Planning Act was designed to create a "delicate but workable" regulatory process to deal with what Congress believed was a problem of unnecessary hospital construction. The Act was carefully constructed to permit the participation of various elements of the industry, together with consumers, in the planning process, but it reserved regulatory duties to the States. The Act specifically left to the States the basic discretion as to how and when to implement the affirmative regulatory elements of the planning process envisioned by the Act.

Respondents here, under the rubric of "implied repeal," assert the right to engage in voluntary private cartel regulation, with no public agency oversight or judicial review, without regard to the antitrust laws. They argue that this was the intent of Congress, ignoring the facts that Con-

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trust laws is necessary to make this statutory scheme effective. The Court believes the answer is yes. *In the Court's view, voluntary cooperation of the entire health care industry, including third party payors, is essential to the success of the Act.* (479 F. Supp. at 1021, J.A. at 186a.) (Emphasis added.)

gress specifically dealt with the scope of immunity under the Planning Act, not only at the time of initial passage but on at least one occasion since, and that Congress rejected various suggestions—including some made by respondent BCA—either to require the conduct at issue here or to broaden the statutory immunity from collateral attack. In the light of the language of the statute and its legislative history, there is no ascertainable basis for a finding that Congress had a "clear and manifest" intention to grant broad immunity from the antitrust laws to all actions—however motivated and whatever their effect—arguably consistent with the generally stated policy goals of the Planning Act. The record shows that Congress knew what immunity it wanted to give and did so.

Nor is there any irreconcilable conflict between the Planning Act and the antitrust laws. The antitrust laws prohibit, *inter alia*, private collusive conduct with either the purpose or effect of unreasonably restraining trade. In some circumstances, such as the group boycott alleged here, conduct is deemed *per se* illegal, and no showing of any particular effect is necessary. The Planning Act requires no such conduct; indeed, it neither requires nor authorizes any coercive conduct of any kind by private entities. Thus, there is no conflict between the two statutory schemes; certainly, it cannot be argued that *pro tanto* repeal of the antitrust laws is "necessary to make the [regulatory scheme] work," which is the "guiding principle" for a conclusion of implied repeal set forth by this Court in *Silver* v. *New York Stock Exchange*, 373 U.S. 341, 357.

Finally, the Planning Act does not create the sort of "pervasive regulatory scheme" that this Court has identified as an important element in finding implied repeal. Here, no federal agency exercises any regulatory jurisdiction of any kind over respondents. No federal or state agency has (much less has exercised) any power pursuant to the Planning Act to approve the conduct at issue here. MAHSA, the agency on whose planning documents the courts below relied so heavily, is a private corporation whose authority

under the Planning Act is limited to making recommendations—hardly the equivalent of the SEC or CAB. In short, there is no regulatory scheme and no regulatory agency of the sort upon whose existence previous implied repeal decisions have been based.

The decisions below have ignored the principle that is the cornerstone of the Sherman Act—that private collusive conduct unsupervised by an independent public body is dangerous to the public interest and thus must be subject to antitrust enforcement. To replace this standard, a subjective test is advanced—whether the private conduct was arguably consistent with the policy of some federal statute. But this Court has never lightly assumed a Congressional intent to turn the powers of government over to private entities with private motives. Even where there is some involvement by a public body, this Court has searched to see whether its supervision would assure that the public interest would predominate. *See, e.g., California Retail Liquor Dealers Association* v. *Midcal Aluminum, Inc.*, 445 U.S. 97, 106, where this Court said, in language fully applicable here, that "[t]he national policy in favor of competition cannot be thwarted by casting . . . a gauzy cloak of state [or public] involvement over what is essentially a private . . . arrangement."

The "gauzy cloak" of implied repeal should not be allowed to protect the purely private action challenged here, with its inherent conflicts of interest and total absence of due process. Congress did not intend such a result. The decision below to the contrary is erroneous and should be reversed.

ARGUMENT

I.

Introductory Statement

This case involves the application of the antitrust laws to the health care industry—an industry which already

accounts for almost one-tenth of this nation's total GNP [8] and represents the single largest component of the services sector of our economy.[9]

Until very recently, health care providers and insurers were largely insulated from the market forces that regulate, more or less directly, most other sectors of our national economy. *See, e.g.*, C. Havighurst, "Professional Restraints on Innovation in Health Care Financing," 1978 *Duke L.J.* 303, 343 (1978). In recent years, however, more and more commentators and legislators have begun to advocate increased reliance on market forces as a means to encourage more effective and efficient delivery of health care services.[10]

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[8] *See* M. Freeland, G. Calat & C. Schendler, "Projections of National Health Expenditures, 1980, 1985, and 1990," *Health Care Financing Review* 1, 6 (Winter, 1980). Between 1965 and 1978, health care expenditures as a percentage of GNP rose from 6.2% in 1965 to 9.1% in 1978, and are expected to rise to 11.5% in 1990. *Id.* at 6. Growth has been especially great for the services funded by third parties such as respondent Blue Cross. Health Care Financing Administration, *Health Care Financing Trends* 1 (Spring 1980).

[9] *Health Services Policy Session* (briefing book prepared by Federal Trade Commission Staff, 1979), at 1.

[10] *See, e.g.*, Address by A. E. Kahn, "Health Care Economics: Paths to Structural Reform," American Enterprise Institute Conference on Health Care (Sept. 25, 1980); W. McClure, "On Broadening the Definition of and Removing Regulatory Barriers to a Competitive Health Care System," 3 *J. of Health Politics, Policy and Law* 303 (1978); M. Pollard, "Fostering Competition in Health Care," in *Regulating Health Care: The Struggle for Control*, 33 *Proceedings of the Academy of Political Science* 158 (A. Levin ed. 1980); P. Ellwood, "Alternatives to Regulation: Improving the Market," in *Controls on Health Care, Papers of the Conference on Regulation in the Health Industry* (National Academy of Sciences 1975); J. Christianson and W. McClure, "Developing a Regulatory Strategy Consistent with a Competitive Health Care System," in

Simultaneously, recent decisions of this Court have reduced traditional legal barriers to the increased influence of market forces in the health care industry.

In *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, and *National Society of Professional Engineers* v. *United States*, 435 U.S. 679, for example, this Court rejected the contention that the "learned professions" are exempt from the requirements of the antitrust laws. In *California Retail Liquor Dealers Association* v. *Midcal Aluminum, Inc.*, 445 U.S. 97, and predecessor cases,[11] this Court significantly

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Socioeconomic Issues of Health 1980 103 (American Medical Association 1980); A. Enthoven, "Health Care Costs: Why Regulation Fails, Why Competition Works, How to Get There from Here," 11 *National Journal* 885 (May 26, 1979); R. Posner, "Certificates of Need for Health Care Facilities: A Dissenting View," in *Regulating Health Facilities Construction* 113 (C. Havighurst ed. 1974); R. Helms, "Regulating the Cost of Health Care: Can We Learn from Experience?" (American Enterprise Institute 1978). *See also* S. Allalouf, "Letting Market Forces Help Govern Provision of Health Care," *New York Times*, Feb. 9, 1981, at A19.

In the last Congress alone, three bills were introduced which were intended to promote competition within the health care industry as a means of curbing costs: S. 1590 (The Comprehensive Health Care Reform Act), 96th Cong., 1st Sess. (1979); S. 1968 (The Health Incentives Reform Act), 96th Cong., 1st Sess. (1979); and H.R. 5740 (The Health Cost Restraint Act), 96th Cong., 1st Sess. (1979). At least one bill, H.R. 850 (The National Health Care Reform Act of 1981), 97th Cong., 1st Sess. (1981), has already been introduced in this Congress.

[11] *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773 (rejecting claim by the Fairfax County Bar that the ethical codes and activities of the State Bar "prompted" it to issue fee schedule, thus immunizing it from the antitrust laws); *see City of Lafayette* v. *Louisiana Power & Light Co.*, 435 U.S. 389; *Cantor* v. *Detroit Edison Co.*, 428 U.S. 579. *See also New Motor Vehicle Board of California* v. *Orrin W. Fox Co.*, 439 U.S. 96; *Bates* v. *State Bar of Arizona*, 433 U.S. 350.

narrowed the *Parker* v. *Brown* [12] "state action" exemption, which now provides only a limited shield for anticompetitive private actions voluntarily taken as a response to state law and regulatory regimes. In *Hospital Building Co.* v. *Trustees of Rex Hospital,* 425 U.S. 738, this Court interpreted the Sherman Act to reach local activities of health care providers if they had a significant effect on interstate commerce. In *Group Life and Health Insurance Co.* v. *Royal Drug Co.,* 440 U.S. 205, this Court, specifically noting that "exempting provider agreements from the antitrust laws would be likely in at least some cases to have serious anticompetitive consequences" (440 U.S. at 232, n.40), concluded that pharmacy provider agreements were not within the McCarran-Ferguson Act exemption from the antitrust laws. In sum, in the process of developing the rules of law applicable to health care providers and insurers, the decisions of this Court have increased the opportunity for competition to function with greater effectiveness in the health care industry.

The rationale of the decisions below, if adopted by this Court, would seriously restrict the growing influence of competition policy in the health care sector. It would provide an umbrella of protection for many types of anticompetitive activities, so long as they could be said to be in some way consistent with the goals of the Planning Act. Nothing in either the language or the legislative history of the Planning Act supports the view that Congress intended such a result; in fact, both strongly suggest the contrary. Nor are the Planning Act and the antitrust laws in any way irreconcilable; the Act neither commands nor permits any action prohibited by the antitrust laws and the regulatory process envisioned by the Act does not require the ouster of the antitrust laws. Unless cartel regulation in the health care industry is to be the result, the decision of the Court of Appeals should be reversed.

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[12] 317 U.S. 341.

II.

Under The Guidelines Established By This Court, There Is No Basis Here For Finding An Implied Repeal Of The Sherman Act.

The decision below departs radically from the legal principles governing implied repeal established by this Court in a long line of decisions. "It is . . . a cardinal principle of statutory construction that repeals by implication are not favored." *Radzanower* v. *Touche Ross & Co.*, 426 U.S. 148, 154, *quoting United States* v. *Continental Tuna Corp.*, 425 U.S. 164, 168.[13] This Court has clearly established that, where a fundamental national policy is at issue, a finding of implied repeal is not appropriate unless there exists a "clear and manifest" expression that Congress intended such repeal. *Tennessee Valley Authority* v. *Hill*, 437 U.S. 153, 189-90; *Morton* v. *Mancari*, 417 U.S. 535, 550. *See also Posadas* v. *National City Bank*, 296 U.S. 497, 503. "In practical terms, this . . . means that '[i]n the absence of some affirmative showing of an intention to repeal, the only permissible justification for a repeal by implication is when the

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[13] In his dissenting opinion in *Radzanower*, Justice Stevens explained the reason for this rule as follows:

> The rule that repeals by implication are not favored, like all other canons of statutory construction, is merely one of the guidelines to observe in the search for a construction which will best reflect the real intent of the legislature. When we are dealing with a well-established and clearly defined old rule, it is usually reasonable to suppose that the legislative intent to change such a rule would be unambiguously expressed. Or if we are dealing with an old rule that is an established and important part of our national policy, we must be sure that it is not changed simply by inadvertent use of broad statutory language. *Thus, if Congress intended* to modify the long-settled practice of preferential hiring of Indians on Indian reservations, or *to limit the coverage of a statute as important as the Sherman Act, a court would require an unambiguous expression of intent to make such a change;* without such an expression it is reasonable to believe that inadvertence, rather than an intent to repeal, is the actual explanation for the broad language that arguably changes the old rule. . . . [426 U.S. at 164; footnotes omitted; emphasis added.]

earlier and later statutes are irreconcilable.'" *Tennessee Valley Authority* v. *Hill*, 437 U.S. 153, 190, *quoting Morton* v. *Mancari*, 417 U.S. 535, 550.

The antitrust laws represent our "fundamental national economic policy." *Carnation Co.* v. *Pacific Westbound Conference*, 383 U.S. 213, 218. The antitrust laws (and specifically the Sherman Act) have been characterized by this Court as "the Magna Carta of free enterprise, . . . as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms." *City of Lafayette* v. *Louisiana Power & Light Co.*, 435 U.S. 389, 398. Mr. Justice Black, writing for the Court in *Northern Pacific Railway Co.* v. *United States*, 356 U.S. 1, 4, perhaps best articulated the principle:

> The Sherman Act was designed to be a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade. It rests on the premise that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic political and social institutions. But even were that premise open to question, the policy unequivocally laid down by the Act is competition.

Thus, there can be no doubt that the "clear and manifest" intention standard must be met when the issue is implied repeal of the antitrust laws. *See United States* v. *Borden Co.*, 308 U.S. 188, 198-99 ("intention of the legislature to repeal must be 'clear and manifest'"); *Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659, 682 ("[r]epeal of the antitrust laws by implication is not favored and not casually to be allowed"); *California* v. *Federal Power Commission*, 369 U.S. 482, 485 ("[i]mmunity from the antitrust laws is not lightly implied"). *See also Federal Maritime*

Commission v. *Seatrain Lines, Inc.*, 411 U.S. 726, 733. As Mr. Justice Brennan wrote, "[t]he presumption against repeal by implication reflects the understanding that the antitrust laws establish overarching and fundamental policies . . . ." *City of Lafayette* v. *Louisiana Power & Light Co.*, 435 U.S. 389, 399.

Given this heavy burden, advocates of implied repeal have frequently advanced the existence of a federal regulatory scheme as requiring the conclusion that Congress intended to repeal the antitrust laws. More than the mere presence of some scheme of federal regulation must, however, be shown to justify the ouster of antitrust protection for either the regulated industry or specific activities subject to federal regulation. *See Carnation Co.* v. *Pacific Westbound Conference*, 383 U.S. 213, 218 (". . . we cannot lightly assume that the enactment of a special regulatory scheme for particular aspects of an industry was intended to render the more general provisions of the antitrust laws wholly inapplicable to that industry"); *Otter Tail Power Co.* v. *United States*, 410 U.S. 366, 372 ("[a]ctivities which come under the jurisdiction of a regulatory agency nevertheless may be subject to scrutiny under the antitrust laws"). Recognizing the "indispensable role of antitrust policy in the maintenance of a free economy," this Court has concluded that "[r]epeals of the antitrust laws by implication from a regulatory statute are strongly disfavored, and have only been found in cases of plain repugnancy between the antitrust and regulatory provisions." *United States* v. *Philadelphia National Bank*, 374 U.S. 321, 348, 350-51 (footnotes omitted). Moreover, any implied immunity must be narrowly limited to that "necessary to make the [regulatory scheme] work and even then only to the minimum extent necessary." *Silver* v. *New York Stock Exchange*, 373 U.S. 341, 357; *see Cantor* v. *Detroit Edison Co.*, 428 U.S. 579, 596 n.34; *Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659, 682; *United States* v. *National Association of Securities Dealers, Inc.*, 422 U.S. 694, 734;

Federal Maritime Commission v. *Seatrain Lines, Inc.*, 411 U.S. 726, 733.

In the remainder of this brief, we will undertake to show (A) that there is no "clear and manifest" indication of Congressional intent to repeal the antitrust laws, either in the language of the Planning Act or in its legislative history, and (B) that there is no irreconcilable conflict between the Planning Act and the antitrust laws. In failing to recognize these points, the decisions below have fundamentally misconstrued the implied immunity doctrine.

A. Neither the language nor the legislative history of the Planning Act gives any "clear and manifest" indication that Congress intended implied repeal.

Neither the legislative history of the Planning Act nor the Act itself provides any indication that Congress intended to exempt respondents' action from antitrust scrutiny. The Court of Appeals nevertheless presumed such intent, relying largely on the general observation by Congress that the health care industry had failed to "respond to classic marketplace forces" and its concern with rapidly rising health care costs. (628 F.2d at 1056, J.A. at 209a.) In addition, it gave great weight to comments made by a single Representative long after the Act was passed to support its conclusion that Blue Cross' voluntary action was immune under the antitrust laws. (628 F.2d at 1056-57, J.A. at 211a-213a.) None of these indicia of purported Congressional intent, however, constitute the type of "unequivocally declared Congressional purpose" which this Court has held is required before implied repeal of the antitrust laws may be presumed. *See Pan American World Airlines, Inc.* v. *United States*, 371 U.S. 296, 305.

The best evidence of Congressional intent, of course, is the statute itself. *Greyhound Corp.* v. *Mt. Hood Stages, Inc.*, 437 U.S. 322, 330, *quoting Blue Chip Stamps* v. *Manor Drug Stores*, 421 U.S. 723, 756 (Powell, J., concurring)

("The starting point in every case involving construction of a statute is the language itself."). Nothing in the language of the Planning Act demonstrates any Congressional desire to oust the antitrust laws; indeed, the statute itself compels the opposite conclusion.

While not mentioned in either opinion below, Congress specifically included in the Planning Act a limited immunity from antitrust (and other) damage actions for individual members and employees of HSAs.[14] Significantly, that provision did not include any immunity for other private parties. In 1979, that provision was the subject of more consideration, and the exemption was broadened—but only to include the HSA itself.[15] The fact that Congress provided only

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[14] *See* National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, § 1512(b)(4), 88 Stat. 2225 (1974), which reads:

> No individual who, as a member or employee of a health systems agency, shall, by reason of his performance of any duty, function, or activity required of, or authorized to be undertaken by, the agency under this title, be liable for the payment of damages under any law of the United States or any State (or political subdivision thereof) if he has acted within the scope of such duty, function, or activity, has exercised due care, and has acted, with respect to that performance, without malice toward any person affected by it.

[15] *See* Health Planning and Resources Development Amendments of 1979, Act of October 4, 1979, Pub. L. No. 96-79, § 110(d)(1), 93 Stat. 603-04 (1979), which reads:

> (4) LIABILITY.—
>
> (A) IN GENERAL.—Except as provided in subparagraph (B)—
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> (i) a health systems agency shall not, by reason of the performance of any duty, function, or activity, required of, or authorized to be undertaken by, the agency, be liable for the payment of damages under any law of the United States or any State (or political subdivision thereof) if the member of the governing body of the agency or employee of the agency who acted on behalf of the agency in the performance of such duty, function, or activity acted within the scope of his duty, function, or activity as such a member or employee, exercised due

a narrow and limited immunity is strong evidence that it intended no broader immunity to be created by implication. *See Federal Maritime Commission* v. *Seatrain Lines, Inc.*, 411 U.S. 726, 733; *Carnation Co.* v. *Pacific Westbound Conference*, 383 U.S. 213, 216-19; *California* v. *Federal Power Commission*, 369 U.S. 482, 485; *Cain* v. *Air Cargo, Inc.*, 599 F.2d 316, 320 (9th Cir. 1979). Thus, in *United States* v. *Borden Co.*, 308 U.S. 188, 201, this Court found that the explicit immunity provisions contained in the Agricultural Marketing Agreement Act defined the extent to which Congress intended to displace the Sherman Act:

> If Congress had intended to grant any further immunity, Congress doubtless would have said so.

This reasoning is clearly applicable here.

This conclusion becomes inescapable when one considers the fact that Congress *considered and rejected* several immunity provisions broader than that ultimately enacted—though not as sweeping as that urged by respondents and found by the courts below. The American Health Planning Association argued that "organizations, their employees,

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care, and acted without malice toward any person affected by it; and

(ii) no individual member of the governing body of a health systems agency or employee of a health systems agency shall, by reason of his performance on behalf of the agency of any duty, function, or activity required of, or authorized to be undertaken by, the agency, be liable for the payment of damages under any law of the United States or any State (or political subdivision of a State) if he believed he was acting within the scope of his duty, function, or activity as such a member or employee, and, with respect to such performance, acted without gross negligence or malice toward any person affected by it.

(B) EXCEPTION.—Subparagraph (a) does not apply with respect to civil actions for bodily injury to individuals or physical damages to property brought against a health systems agency or any member of the governing body of or employee of such an agency.

Board members and agents who voluntarily follow the recommendation of a SHPDA or HSA made in conformance with the requirements of this act" should be immunized. Similarly, the American Medical Association urged that "[a] new section . . . be added to exempt actions taken in meeting the requirements of the Act from federal antitrust laws." *See* Health Planning and Resources Development Amendments of 1979: Hearings before the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce on H.R. 3041 and 3167, 96th Cong., 1st Sess. 187-88, 641 (1979). Significantly, the Conference Committee rejected even a more limited Senate amendment, which would have extended immunity to "agents and consultants" of the HSA. *See* H. Conf. Rep. No. 420, 96th Cong., 1st Sess. 66, *reprinted in* [1979] U.S. Code Cong. & Ad. News 1422, 1434. This record is hardly consistent with an assumption that Congress intended the wholesale repeal of the antitrust laws in this area.

Indeed, the very language of the provision on which the courts below primarily relied for their conclusions of Congressional intent demonstrates that Congress recognized the existence of finite limits on the cooperation of private entities with an HSA:

> A health systems agency shall implement its HSP [Health Systems Plan] and AIP [Annual Implementation Plan], and in implementing the plans it shall perform at least the following functions:
>
> (1) The agency shall seek, *to the extent practicable*, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area. (42 U.S.C. §300*l*-2(c)(1); emphasis added.)

Unless we are to assume they are mere surplusage, the words "to the extent practicable" must demonstrate a Congressional understanding that private "assistance" would not always be available. Boycotts, bribery, threats, and other forms of coercion might be effective tools in the

hands of an HSA or private parties seeking a particular result, but they are forbidden to private and public entities alike by criminal statutes. Obviously, Congress recognized that illegal coercive conduct by private entities, even if thought useful by or helpful to the HSA, would not be desirable and should not be encouraged.[16]

Again, what Congress specifically did not do is instructive. As originally passed by the House of Representatives, the Planning Act would have allowed the states to forbid private insurance reimbursement for certain capital expenditures that were not approved by local planning agencies. (*See, infra,* at p. 37.) This provision was rejected by the conference committee, and was not included in the Planning Act as ultimately adopted. It hardly seems likely that Congress rejected a regulatory provision commanding certain conduct, but intended similar private collusive conduct, without oversight by or the protection of government regulators, to be totally immune from antitrust attack.

On this record, a finding that Congress had a "clear and manifest" intention to create a blanket exemption from the antitrust laws for actions arguably consistent with the policy goals of the Planning Act has no ascertainable foundation.[17] The record shows that Congress knew what immunity it wanted to give and did so.

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[16] Of course, private cooperation could be limited by constraints other than statutory prohibitions. The private interests of individual providers might not always be consistent with the efforts or goals of local planning bureaucracies. Congress obviously was aware of this possibility; nevertheless, it left neither the HSA nor any other agency with any regulatory power to compel "assistance." It would be incongruous, to say the least, if the Planning Act were interpreted to permit private cartels to exercise powers specifically withheld from any agency (private or public) involved in the planning process created by the Act.

[17] The comments by Representative Rogers so heavily relied on by the courts below were made during debates on amendments to

B. The Planning Act and the antitrust laws are not irreconcilable.

As we have contended above, nothing in either the language or the legislative history of the Planning Act suggests a Congressional intention to repeal the antitrust laws in the health care industry. As this Court has emphasized, in such circumstances "[t]he courts are not at liberty to pick and choose among congressional enactments, and when two statutes are capable of co-existence, it is the duty of the courts, absent a clearly expressed congressional intention to the contrary, to regard each as effective." *Morton* v. *Mancari*, 417 U.S. 535, 551. Only when there is "plain repugnancy" between two statutes can the doctrine of implied repeal be appropriately applied. *United States* v. *Philadelphia National Bank*, 374 U.S. 321, 348, 350-51; *see Tennessee Valley Authority* v. *Hill*, 437 U.S. 153, 190-93; *Radzanower* v. *Touche Ross & Co.*, 426 U.S. 148, 154-55; *Silver* v. *New York Stock Exchange*, 373 U.S. 341, 357; *Posadas* v. *National City Bank*, 296 U.S. 497, 503-05. As this Court observed in *Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659, 683,

> Concluding that the proper approach to the problem was to reconcile the operation of the antitrust laws with a regulatory scheme, the Court [in *Silver*] established a "guiding principle" for the achievement of

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the Act proposed in 1978 but never enacted. *See* H.R. 11488, 95th Cong., 2d Sess. (1978). Obviously, the views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one (*see United States* v. *Philadelphia National Bank*, 374 U.S. 321, 348-49); *a fortiori*, the words of a single Congressman in an unsuccessful amendment effort hardly provide a sound basis for inferring that his remarks reflect the intent of Congress in passing the original legislation. *See, e.g., Tennessee Valley Authority* v. *Hill*, 437 U.S. 153, 209 (Powell, J., dissenting), citing *Regional Rail Reorganization Cases*, 419 U.S. 102, 132 ("We have held properly that post-enactment statements by individual Members of Congress as to the meaning of a statute are entitled to little or no weight.").

> this reconciliation. Under this principle, "[r]epeal is to be regarded as implied only if necessary to make the [regulatory scheme] work, and even then only to the minimum extent necessary."

The Court of Appeals ignored this "guiding principle," and made no attempt to reconcile the Planning Act with the antitrust laws. Instead, without supportive reasoning or analysis of the key provision at issue, it concluded that "the Act and the regulatory scheme clearly call for the action which has now become the basis of an antitrust claim." (628 F.2d at 1055-56, J.A. at 209a.) This was both factual and legal error.

1. *The Planning Act neither requires nor authorizes the conduct at issue here.*

The Planning Act was enacted "to facilitate the development of recommendations for a national health planning policy, to augment areawide and State planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy." 42 U.S.C. § 300k(b). To accomplish that purpose, the Act established, through a series of grants made by the Department of Health, Education and Welfare [now the Department of Health and Human Services ("DHHS")] a nationwide, three-tiered system of health planning and development organizations (*see* 42 U.S.C §§ 300*l*-1, 300m, 300m-3).[18] It also encouraged the states to establish their

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[18] The first of these agencies is the Health Systems Agency ("HSA"), which may be a non-profit private corporation, a public regional planning body, or a single unit of local government. 42 U.S.C. § 300*l*(b)(1). The HSA involved in this case, MAHSA, was a private corporation. The primary functions of the HSA are to develop health plans for their respective service areas, and to make recommendations regarding certificate of need applications, and the need for existing services. 42 U.S.C. §§ 300*l*-2(b),(f),(g)(1) and (2).

The second agency, the State Health Planning and Development Agency ("State Agency"), is the public agency selected by the

own "certificate of need" programs to regulate the provision of new or expanded health care services (*see* 42 U.S.C. § 300m).[19] The duties of the Secretary of DHHS under this statutory scheme are very limited,[20] and include no "regulatory" functions whatever. Indeed, as is clearly indicated in the legislative history of the Act, the Planning Act established a framework for the future development of a national planning policy in which the only truly "regulatory" function would be served by each state pursuant to its own

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Governor of each state to serve as the designated planning agency of the state. This agency, in addition to preparing a state health plan, also administers the state's certificate of need program under which the addition of new and expanded health care services is regulated by the state. 42 U.S.C. § 300m *et seq.*

The third agency, the Statewide Health Coordinating Council ("SHCC"), coordinates the plans of the HSAs within the state, and revises and approves or disapproves the state health plan submitted by the State Agency. 42 U.S.C. § 300m-3. It is not directly involved in the state certificate of need process.

[19] Under the Act, a state is not required to participate in the planning program, but it faces the loss of various grants, loans or contract monies available from the federal government if it fails to do so. 42 U.S.C. § 300m(d).

[20] The primary responsibilities of the Secretary are to issue guidelines concerning national health planning goals (*see* 42 U.S.C. § 300k-1); to establish health service areas (*see* 42 U.S.C. § 300*l*); and to enter into designation agreements for HSAs and State Agencies (*see* 42 U.S.C. §§ 300*l*-4, 300m). The Planning Act also establishes a National Council on Health Planning and Development to advise and make recommendations to the Secretary for the development of national health planning guidelines (*see* 42 U.S.C. § 300k-3), pursuant to which the Secretary has promulgated planning guidelines intended to be used by the HSAs in developing their health plans (*see* 42 C.F.R. §§ 121.201 *et seq.* (1979)).

individualized "certificate of need" legislation.[21] In fact, the only "regulatory" feature of the entire planning scheme is the certificate of need legislation enacted by the states.[22] The Planning Act, by itself, does not create a federal regulatory scheme nor does it vest pervasive regulatory powers in any federal agency.

The courts below relied primarily on section 300*l*-2(c)(1) as establishing the authority of the Planning Act, and the exclusion of antitrust jurisdiction, for the conduct challenged here. Inexplicably, however, neither court gave any particular attention to the actual words used by Congress in that provision. It reads as follows:

> A *health systems agency* shall implement its HSP [Health Systems Plan] and AIP [Annual Implementation Plan], and in implementing the plans it shall perform at least the following functions:
>
> (1) *The agency* shall seek, to the extent practicable, to implement its HSP and AIP with the assistance of

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[21] The Senate Report reads:

> Although the keystone to the health planning effort envisioned . . . is the area-wide health planning agency, certain functions are more appropriately performed at the State level. Specifically . . . the performance of regulatory functions are most appropriately carried out at the State level . . . [This] function can appropriately be carried out only by an agency of State Government. The Committee bill is intended to encourage the establishment of a delicate but workable balance among the varied interests operating in the health industry today. For that reason, rather detailed and explicit enumerations of the health planning and regulatory functions which can be carried out at the State level are contained in the legislation. To a very great extent, the manner in which those [regulatory] functions are performed is left to the discretion of the individual Governors of the states involved. [S. Rep. No. 1285, 93d Cong., 2d Sess. 52, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7891.]

[22] As noted *supra* at p.4 n.3, at all times here pertinent, Missouri had no compulsory certificate of need program, nor had it designated a State Agency.

> individuals and public and private entities in its health service area. (42 U.S.C. § 300*l*-2(c)(1); emphasis added).

Even a casual reading of this language shows that it neither calls for nor authorizes any conduct by private parties, much less a boycott by a dominant third-party payor acting in concert with others. The provision plainly speaks to "the agency" and not to private entities; to the extent this provision requires, authorizes or encourages *any* conduct, it is *only* conduct by the agency itself. Here, the record clearly shows that the action complained of was *not* taken *by, or at the request of,* any health systems agency. As respondent BCA itself has conceded, the Blue Cross policy was "unilaterally adopted" (BCA Br. in Opp. at 11),[23] and, as the court below found, it was totally voluntary (628 F.2d at 1057, J.A. at 213a). Neither MAHSA nor any other federal or state government agency required respondents to act as they did, nor did MAHSA or any other government agency have the legal authority to approve or sanction the boycott, even if asked.

This provision is typical; the Planning Act nowhere compels, mandates or authorizes anticompetitive action by private parties. The Act does encourage local and state planning agencies to seek the cooperation of private entities, and the Act obviously envisioned communications with private entities and individuals. But it is too much by far to say that the Planning Act in any way—much less "clearly" —authorized, approved or even encouraged violations of other federal statutes by private parties acting of their own volition outside the framework created by the Act.

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[23] While BCA may mean to exclude itself and others from the decision by this language, which begs the ultimate question at stake in this litigation, at a minimum this admission concedes the conduct challenged here was not undertaken pursuant to any governmental mandate.

This Court has long been unsympathetic to "private government," whatever its motives or form. *See, e.g., California Retail Liquor Dealers Association* v. *Midcal Aluminum, Inc.*, 445 U.S. 97; *Fashion Originators' Guild* v. *Federal Trade Commission*, 312 U.S. 457; *United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. 150; *American Medical Association* v. *United States*, 130 F.2d 233 (D.C. Cir. 1942), *aff'd*, 317 U.S. 519.

In *Fashion Originators' Guild*, for example, manufacturers of women's clothing combined to boycott retailers who sold clothing that Guild members believed was copied from their original designs. The Guild argued that the copying violated state laws and that their activity was thus consistent with and supportive of state law. This Court held that this effort violated the antitrust laws, describing the Guild as "in reality an extra-governmental agency, which prescribes rules for the regulation and restraint of interstate commerce, and provides extra-judicial tribunals for determination and punishment of violations, and 'thus trenches upon the power of the national legislature, and violates the statute.' *Addyston Pipe and Steel Co.* v. *United States*, 175 U.S. 211, 242." 312 U.S. at 465-66. As for the claim of assisting the enforcement of state law, the Court held that "even if copying were an acknowledged tort under the law of every state, that situation would not justify petitioners in combining together to regulate and restrain interstate commerce in violation of federal law." 312 U.S. at 468.

Even where government agencies have encouraged private regulation, this Court has struck it down where it had no explicit Congressional authorization. In *Socony*, for example, defendants argued that federal government officers were aware of and had approved their scheme to stabilize the price of distress gasoline. The Court rejected the contention that this conferred antitrust immunity (310 U.S. at 226-27):

> For Congress had specified the precise manner and method of securing immunity. None other would suffice.

> Otherwise national policy on such grave and important issues as this would be determined not by Congress nor by those to whom Congress had delegated authority but by virtual volunteers.

Most recently, this Court found no antitrust immunity even where a state legislature had enacted a statute specifically directing the conduct attacked. *California Retail Liquor Dealers Association* v. *Midcal Aluminum, Inc.*, 445 U.S. 97. It is not enough that the challenged restraint is "clearly articulated and affirmatively expressed as state policy," said this Court; it must also be " 'actively supervised' by the State itself." 445 U.S. at 105. This holding was synthesized from a series of opinions by this Court, including decisions finding no immunity from antitrust attack for conduct by "a state agency for some limited purposes" (*Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, 791), or for conduct "passively accepted" by a state agency (445 U.S. at 104, *citing Cantor* v. *Detroit Edison Co.*, 428 U.S. 579), and finding antitrust immunity for rules promulgated by the Supreme Court of a state only because they were "subject to pointed reexamination by the policymaker—the Arizona Supreme Court—in enforcement proceedings" (445 U.S. at 104-05, *quoting Bates* v. *State Bar of Arizona*, 433 U.S. 350, 362).[24] *Cf. Gibson* v. *Berryhill*, 411 U.S. 564 (find-

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[24] Although the court below apparently viewed the "state action" doctrine and its standards as being totally irrelevant in the context of this case (*see* 628 F.2d at 1054-55; J.A. at 206a-207a), the standards used by this Court in the implied repeal and state action areas are, in fact, not dissimilar. *See Cantor* v. *Detroit Edison Co.*, 428 U.S. 579, 597-98. Certainly, the lower courts have freely applied the standards applicable to the state action doctrine in the implied immunity context. *See, e.g., Essential Communications Systems, Inc.* v. *American Telephone & Telegraph Co.*, 610 F.2d 1114, 1124 (3d Cir. 1979); *City of Mishawaka* v. *Indiana & Michigan Electric Co.*, 560 F.2d 1314, 1320 (7th Cir. 1977), *cert. denied*, 436 U.S. 922. *See also* Note, "Antitrust and Regulated Industries: A Critique

ing a state licensing board so biased by the pecuniary interest of its members that its proceedings were constitutionally defective).

There is a common thread here—the importance of independent public decisionmaking—and this notion has been repeatedly mentioned in the regulatory implied repeal cases. Voluntary private conduct is not automatically immunized from antitrust scrutiny simply because it falls within the jurisdiction of a regulatory agency, *see Otter Tail Power Co.* v. *United States,* 410 U.S. 366, or even if it is actually approved by a public agency with clear regulatory authority. *See, e.g., Cantor* v. *Detroit Edison Co.,* 428 U.S. 579, 592-95; *United States* v. *Philadelphia National Bank,* 374 U.S. 321, 350-52; *California* v. *Federal Power Commission,* 369 U.S. 482, 485; *United States* v. *Radio Corp. of America,* 358 U.S. 334, 350-52.

Here, there is no public agency with the power to approve or authorize, and thus there is no actual agency approval—either at the federal or state level. Nor is there any regulatory conflict of the type which this court has found to justify a conclusion of implied repeal. For example, in *Gordon* v. *New York Stock Exchange, Inc.,* 422 U.S. 659, this Court concluded that the Securities and Exchange Act of 1934, which authorized the Securities and Exchange Commission to approve or disapprove exchange commission rates, impliedly repealed the antitrust laws as to the exchange's system of fixed commission rates. This Court found that the relevant federal statute clearly contemplated that the securities exchanges would engage in the very conduct challenged subject to the supervision and review of the SEC. Thus, this Court noted that "the Congress gave clear authority to the 'fixing of reasonable rates of commission'" under SEC supervision (422 U.S. at 681), and

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and Proposal for Reform of the Implied Immunity Doctrine," 57 *Tex. L. Rev.* 751 (1979).

concluded that "to deny antitrust immunity with respect to commission rates would be to subject the exchanges and their members to conflicting standards." 422 U.S. at 689. As Mr. Justice Douglas explained in his concurring opinion (422 U.S. at 692):

> The antitrust laws are designed to safeguard a strong public interest in free and open competition, and immunity from those laws should properly be implied only when some equivalent mechanism is functioning to protect that public interest.

Conversely, where the private party is the real decision-maker, and where ouster of the antitrust laws will leave the public with neither antitrust nor adequate regulatory protection, this Court has never found a Congressional intent to exempt such conduct completely from antitrust scrutiny. *See Otter Tail Power Co.* v. *United States*, 410 U.S. 366, 374-75; *Carnation Co.* v. *Pacific Westbound Conference*, 383 U.S. 213, 219; *United States* v. *Philadelphia National Bank*, 374 U.S. 321, 351; *Silver* v. *New York Stock Exchange*, 373 U.S. 341, 353-54, 357.[25] *Cf. California Retail Liquor*

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[25] As noted by this Court in *Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659, 683-84:

> In *Silver*, the Court concluded that there was no implied repeal of the antitrust laws in that factual context because the Exchange Act did not provide for SEC jurisdiction or review of particular applications of rules enacted by the exchanges. . . . [*T*]*here was no governmental oversight of the exchange's self-regulatory action, and no method of insuring that some attention at least was given to the public interest in competition.* (Emphasis added.)

The case for implied repeal is even less compelling in this boycott case than it was in *Silver*. At least in *Silver*, the SEC exercised general oversight over the activities of the exchanges, even though it did not review the particular applications of the rules enacted by them. In this case, no federal agency has any comparable general supervisory authority over the operations of either BCA or Blue Cross.

Dealers Association v. *Midcal Aluminum, Inc.*, 445 U.S. 97, 104-06; *Cantor* v. *Detroit Edison Co.*, 428 U.S. 579, 592-95. Yet this is exactly what the court below did: It created an antitrust exemption for purely private conduct over which there was no public oversight of any kind.[26]

"When . . . relationships are governed in the first instance by business judgment and not regulatory coercion, courts must be hesitant to conclude that Congress intended to override the fundamental national policies embodied in the antitrust laws." *Otter Tail Power Co.* v. *United States*, 410

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[26] The anticompetitive potential here is clear, and even more severe than that generally inherent in the planning process. Even where governmental and quasi-governmental bodies are involved, the competitive dangers are very real:

> If health planners and regulators have generally been liberal in granting certificates-of-need to existing institutions seeking to upgrade and expand their services, they have been relatively stingy about investments by would-be newcomers to the market. . . .
>
> Of course, the strongly political character of planning and regulation, explicitly built into the HSA structure by "consumer" and "provider" representation requirements and implicit in state-level regulation, has encouraged decisions that reflect the interests of established providers. Health planners and regulators, even if they are not "captured" by the regulated institutions, may harbor a preference for stability and cooperative problem solving over what they see as an unruly competitive marketplace.
>
> Thus, they may protect providers from competition in order to gain their cooperation and support. Planners and regulators may also prevent "cream-skimming" by new competitors so that existing providers can continue to price some services above competitive levels. The resulting extraordinary profits may then be used to subsidize unprofitable services that the regulators deem desirable. Protectionist regulation is, in short, used to perpetuate internal subsidies, a regulatory practice that Richard Posner has labeled "taxation by regulation." [C. Havighurst and G. Hackbarth, "Competition and Health Care: Planning for Deregulation," *Regulation*, May/June 1980, at 41.]

U.S. 366, 374[27]; *see Federal Maritime Commission* v. *Seatrain Lines, Inc.*, 411 U.S. 726, 733; *United States* v. *Radio Corp. of America*, 358 U.S. 334.[28] Here, Blue Cross and BCA, in concert with their co-conspirators, established a private regulatory system with no right of appeal and no judicial review. Their action was directly contrary to the

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[27] *Otter Tail* is especially pertinent, because it too deals with "voluntary" actions on the part of private parties. At issue in that case were Otter Tail's consistent refusals to deal with selected municipalities in its market area. Otter Tail claimed that its refusals to deal were immune from antitrust scrutiny because the Federal Power Commission had the authority to regulate certain aspects of the industry. This Court, finding that the Federal Power Act did not confer authority on the FPC to compel involuntary interconnections of power, and that Otter Tail's action was essentially voluntary and "governed in the first instance by business judgment and not regulatory coercion" (410 U.S. at 374), held that the Federal Power Act did not impliedly repeal the antitrust laws.

Here, respondents claim that their collective refusal to deal is immune from antitrust scrutiny because a system of regulation could have commanded the same result. Obviously, the case for implied repeal is far weaker here. Respondents' conduct was not only not coerced; it was not subject to supervision or review of any kind by any public agency—state or federal.

[28] There, in rejecting RCA's claim of implied immunity, this Court reasoned:

> Appellees, like unregulated business concerns, made a business judgment as to the desirability of the exchange. Like unregulated concerns, they had to make this judgment with knowledge that the exchange might run afoul of the antitrust laws. Their decision varied from that of an unregulated concern only in that they also had to obtain the approval of a federal agency. . . . In every sense, the question faced by the parties was solely one of business judgment (as opposed to regulatory coercion). . . . [358 U.S. at 350-51.]

In this case, Blue Cross and its co-conspirators neither sought nor obtained the approval of any federal or state agency. Even if such approval had been sought and given, however, it would not immunize Blue Cross from antitrust liability. *See United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. 150, 225-228.

decision of the State of Missouri, in the exercise of its sovereign powers, not to create a health planning regulatory scheme and not to require any further regulatory approvals of petitioner, and contrary to the Congressional determination not to require any action in support of the Act by third party payors.[29]

But for this litigation, petitioner has no possibility of any relief from this collective action of Blue Cross, BCA and others, for no mechanism for administrative or judicial review of private "need" reviews exists under any law.[30]

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[29] It is interesting to note that BCA itself had attempted to convince the Congress that it should legitimize the very conduct under attack here. *See* National Health Planning and Development Act, 1974: Hearings on S. 2994, S. 3139, S. 2796 and Related Bills Before the Subcommittee on Health of the Committee on Labor and Public Welfare, 93d Cong., 2d Sess. 545-46, 582-83, 585-86, Part 2 (1974) (statement of D. Eugene Sibery, Executive Vice President, Blue Cross Association). BCA was unsuccessful in this effort, but apparently seeks to obtain the same result through private regulation. For BCA (and Blue Cross) to argue that they are merely trying to serve the policies of the Planning Act, when their action is flatly inconsistent with a Congressional decision made during the passage of that Act, is hardly persuasive.

[30] This Court has often identified the lack of opportunity for judicial review of regulatory determinations as a basis for determining whether or not implied repeal is appropriate. For example, in *United States* v. *Philadelphia National Bank*, 374 U.S. 321, 351-52, this Court concluded that the Bank Merger Act had not impliedly repealed the antitrust laws as to the merger at issue, in part because there was no opportunity for judicial review of the administrative decision approving the merger. Similarly, in *Silver* v. *New York Stock Exchange*, 373 U.S. 341, this Court rejected application of the implied repeal doctrine to the denial by the exchange of wire connections to a nonmember, in large part on the ground that there was no opportunity for either judicial or administrative review of the exchange's self-regulatory activity:

> There is nothing built into the regulatory scheme which performs the antitrust function of insuring that an exchange will

The only possible review of the group boycott aimed at petitioner is by an antitrust court. The Planning Act provides no basis for closing this last door.

2. *Antitrust immunity for voluntary, private, anticompetitive conduct is not necessary to make the Planning Act work.*

The implied repeal doctrine has frequently been advanced as a way of resolving a "conflict" between the antitrust laws and the statutory responsibilities of federal regulatory agencies. As described in *United States* v. *National Association of Securities Dealers, Inc.*, 422 U.S. 694, 734:

> [I]mplied immunity [has been found] in particular and discrete instances to assure that the *federal agency entrusted with regulation in the public interest* could carry out that responsibility free from the disruption of conflicting judgments that might be voiced by courts exercising jurisdiction under the antitrust laws. (Emphasis added.)

As we have seen, however, the Planning Act neither commands nor authorizes *any* private anticompetitive conduct, much less boycotts by dominant private third party payors. In fact, nothing in the Planning Act contemplates "regulation" by a "federal agency" that would be at all affected by antitrust enforcement.

> not in some cases apply its rules so as to do injury to competition which cannot be justified as furthering legitimate self-regulative ends. . . . Since the antitrust laws serve, among other things, to protect competitive freedom, i.e., the freedom of individual business units to compete unhindered by the group action of others, it follows that the antitrust laws are peculiarly appropriate as a check upon anticompetitive acts of exchanges . . . [*Id.* at 358-60.]

Conversely, in *Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659, this Court held implied repeal appropriate, specifically noting that a finding of implied repeal was possible only since the commission rate practices at issue were subject to SEC scrutiny and approval, and the SEC determinations were subject to judicial review under the Administrative Procedure Act. *Id.* at 689-90.

Of all the cases decided by this Court on the issue of implied repeal, *Silver* v. *New York Stock Exchange,* 373 U.S. 341, is perhaps the closest on the facts. In *Silver,* the plaintiff was a registered nonmember broker-dealer. He alleged that the defendant Exchange had conspired with its members to deny him access to private wire connections and a stock ticker service. These services were essential to his ability to compete on an equal basis with competitor firms. The Exchange contended that its actions were immune from antitrust scrutiny under the implied repeal doctrine, but this Court disagreed. Noting that the challenged boycott, "in a context free from other federal regulation, [would] constitute a *per se* violation of § 1 of the Sherman Act" (373 U.S. at 347),[31] this Court held that the boycott was not immune from antitrust challenge because the SEC, while it had general regulatory power over the exchanges, had no power to supervise particular applications of the rules of the Exchange.

The Court of Appeals had held that the Exchange was exempted from antitrust constraints because it was acting "within the general scope of [its] authority . . . as defined by the 1934 Act." 373 U.S. at 346. This Court rejected that blunt approach:

> Contrary to the conclusions deduced by the courts below, the proper approach to this case, in our view, is an analysis which reconciles the operations of both statutory schemes with one another rather than holding one completely ousted. . . . Repeal is to be regarded as implied only if necessary to make the Securities Exchange Act work, and even then only to the minimum extent necessary. This is the guiding principle to reconciliation of the two statutory schemes.[32]

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[31] As this Court put it (373 U.S. at 348 n.5): "A valuable service germane to petitioners' business and important to their effective competition with others was withheld from them by collective action. That is enough to create a violation of the Sherman Act."

[32] *See also Cantor* v. *Detroit Edison Co.,* 428 U.S. 579, 597 n.37 ("Recent cases make it clear that the relevant aspect of the

In *Silver*, the SEC had no power to review the conduct at issue. Thus, this Court found, "the question of antitrust exemption does not involve any problem of conflict or coextensiveness of coverage with the agency's regulatory power." 373 U.S. at 358. Nor could this Court find anything "built into the regulatory scheme which performs the antitrust function of insuring that an exchange will not in some cases apply its rules so as to do injury to competition which cannot be justified as furthering legitimate self-regulative ends." *Id.* Thus, said this Court, "[a]pplicability of the antitrust laws . . . rests on the need for vindication of their positive aim of insuring competitive freedom. Denial of their applicability would defeat the Congressional policy reflected in the antitrust laws without serving the policy of the Securities Exchange Act." 373 U.S. at 360.

Here, as in *Silver*, a dominant market force has, in concert with its members and as part of an internal "self-regulatory" scheme, denied a nonmember access to contractual relationships essential to its ability to compete in the market. This is a much clearer case than *Silver*, however, for here the private "self-regulation" is wholly volitional, neither contemplated nor mandated by a federal statute. Moreover, there is no federal regulatory agency which has any power to exercise general regulatory oversight over the boycotters, much less any power to review and control the challenged conduct itself. Thus, there is no "problem of conflict or coextensiveness of coverage" with any federal agency.

Certainly, there can be no argument here that implied repeal is "necessary to make the [Planning Act] work." As the language and legislative history of the Planning Act clearly show, the central focus of the Planning Act scheme

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agency's jurisdiction must be sufficiently central to the purposes of the enabling statute so that implied repeal of the antitrust laws is 'necessary to make the [regulatory scheme] work.' ").

lies in the state certificate of need programs authorized and funded by the Planning Act—not in any coercive actions taken by Blue Cross or other third party payors to limit payments to providers. Section 1421(d) of the House-passed version of the Act would have allowed the states to require third party payors to limit reimbursement payments to health care provider institutions if the institution had not received a favorable "need" determination from the state planning agency, as an alternative to establishing mandatory certificate of need programs.[33] This approach was rejected in conference. *See* H. Conf. Rep. No. 1640, 93d Cong., 2d Sess. 78, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7983, 7987. Thus, Congress refused to adopt a plan of action very similar to that at issue here as a component of the scheme enacted to achieve the goals of the Planning Act. Given this fact, it can hardly be argued that the implementation of respondents' volitional "need" determination policy is at all "necessary" to make the Planning Act work.

Furthermore, there is nothing in either the record or the Act itself to suggest that the type of private activity engaged in by BCA and Blue Cross was ever viewed as at all "necessary" to the achievement of the goals of the Act. The Planning Act as passed nowhere mentions—much less requires—tying third-party reimbursement to need determinations. Nor is there any evidence in the record to indicate that MAHSA ever viewed the "need" determination policy of Blue Cross as being "necessary" to achieving the goals of the Act.[34] Certainly the record is clear that MAHSA

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[33] H.R. 16204, 93d Cong., 2d Sess. (1974). Specifically, under the House version, states electing to participate in the SSA section 1122 Program as an alternative to establishing a mandatory certificate of need program would have been required to extend section 1122 need review to private third party payors such as respondent Blue Cross. *See* H.R. Rep. No. 1382, 93d Cong., 2d Sess. 42, 73 (1974).

never requested Blue Cross to undertake its action, and the MAHSA Health Systems Plan, from which the court below quoted extensively and upon which it so heavily relied (628 F.2d at 1055, J.A. at 207a-209a), contains no mention of the Blue Cross "need" determination policy.[35] Similarly, there is no indication in the record that DHHS ever viewed the Blue Cross policy as being "necessary" to achieve the goals of the Act. As one commentator so aptly put it:

> [T]here is no suggestion that cooperation between HSAs and private insurers is necessary for the Planning Act to function. . . . Invoking platitudes about the need for voluntary cooperation with the planning agency does not substitute for a searching investigation into whether antitrust immunity is necessary to make the regulatory scheme work. [F. Miller, "Antitrust and Certificate of Need: Health Systems Agencies, the Planning Act, and Regulatory Capture," 68 *Georgetown L.J.* 873, 891 (1980).]

In contrast to the schemes of regulation in the banking, securities, airline, electric power and communications industries, the Planning Act hardly creates the kind of "perva-

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[34] Even if there were such evidence, it would hardly be conclusive, since only Congress may repeal a federal statute. *See, e.g., Tennessee Valley Authority* v. *Hill*, 437 U.S. 153, 194 ("[it is] . . . the exclusive province of the Congress not only to formulate legislative policies and mandate programs and projects, but also to establish their relative priority for the Nation."). MAHSA, a private corporation, clearly has no power to do so. Consequently, the apparent reliance of the court below on the MAHSA 1978-1982 Health Systems Plan to support its conclusion of implied repeal is totally misplaced.

[35] As summarized by the court below, the only provisions of the MAHSA Plan dealing specifically with third-party payors relate to the development of uniform reporting systems and procedures—a subject which clearly is not relevant here. (628 F.2d at 1055, J.A. at 208a-209a.)

sive regulatory scheme" this Court has repeatedly identified as an important element in finding implied repeal. *See United States* v. *National Association of Securities Dealers, Inc.*, 422 U.S. 694, 735; *Otter Tail Power Co.* v. *United States*, 410 U.S. 366, 374; *Hughes Tool Co.* v. *Trans World Airlines, Inc.*, 409 U.S. 363, 387; *United States* v. *Philadelphia National Bank*, 374 U.S. 321, 352; *United States* v. *Radio Corp. of America*, 358 U.S. 334, 350-51; *Silver* v. *New York Stock Exchange*, 373 U.S. 341, 347, 360-61; *California* v. *Federal Power Commission*, 369 U.S. 482, 485. *See also* F. Miller, "Antitrust and Certificate of Need: Health Systems Agencies, the Planning Act, and Regulatory Capture," 68 *Georgetown L.J.* 873, 891 (1980) ("in the health industry, regulation is fragmented rather than pervasive"); and 1 Areeda & Turner, *Antitrust Law* ¶ 224, at 145 (1978) ("[i]mmuity is not likely where the agency has relatively little to do with the protection of competition or where its responsibilities for the regulated industry are not 'pervasive'.").[36]

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[36] It may be noted that various proposals were rejected by Congress which would have made the Planning Act scheme significantly more comprehensive than it in fact now is. For example, one of the proposals would have allowed HSAs, in conjunction with State Agencies to eliminate existing "unneeded" health care facilities. Another would have allowed the Secretary of DHEW (now DHHS) to enter into agreements with all State Agencies to regulate and establish rates for health services. *See* H. Conf. Rep. No. 1640, 93d Cong., 2d Sess. 73, 77, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7983, 7987. These rejected provisions, combined with the Act as passed, demonstrate that Congress exercised some care *not* to create a pervasive regulatory scheme.

Furthermore, even in industries where regulation is far more comprehensive than in health care, implied immunity is not necessarily found. *See, e.g., United States* v. *Radio Corp. of America*, 358 U.S. 334; *Sound, Inc.* v. *American Telephone and Telegraph Co.*, 631 F.2d 1324 (8th Cir. 1980); *Essential Communications Systems, Inc.* v. *American Telephone and Telegraph Co.*, 610 F.2d

For example, in *United States* v. *National Association of Securities Dealers, Inc.*, 422 U.S. 694, this Court found that Congress intended that mutual funds have the power to impose vertical restraints on disposition of their securities —the conduct challenged—subject to the review of the Securities and Exchange Commission. This Court reasoned that "maintenance of an antitrust action for activities *so directly related to the SEC's responsibilities* poses a substantial danger that appellees would be subjected to duplicative and inconsistent standards," and therefore concluded that "the Sherman Act has been displaced by the *pervasive regulatory scheme* established by the Maloney and Investment Company Acts." 422 U.S. at 735 (emphasis added).

In *Pan American World Airways, Inc.* v. *United States*, 371 U.S. 296, this Court found that a market division agreement entered into by Pan American was exempt from antitrust scrutiny under section 411 of the Federal Aviation Act of 1958, which gave the Civil Aeronautics Board jurisdiction over "unfair practices and methods of competition" in the airline industry. This Court noted that the CAB has been given "broad jurisdiction over air carriers" (*id.* at 304), and that the "[l]imitation of routes and divisions of territories and the relation of common carriers to air carriers are basic in this regulatory scheme" (*id.* at 305). Consequently, this Court concluded that "[i]f the courts were to intrude independently with their construction of the antitrust laws, two regimes might collide." *Id.* at 310.

Finally, in *Hughes Tool Co.* v. *Trans World Airlines, Inc.*, 409 U.S. 363, this Court held that certain allegedly anticompetitive acts by Toolco, TWA's parent, which were designed

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1114 (3d Cir. 1979); *Litton Systems, Inc.* v. *American Telephone and Telegraph Co.*, 487 F. Supp. 942 (S.D.N.Y. 1980); *Oahu Gas Service, Inc.* v. *Pacific Resources, Inc.*, 460 F. Supp. 1359 (D. Haw. 1978).

to control the acquisition of and financing of aircraft by TWA, were exempt from the antitrust laws under section 408 of the Federal Aviation Act, which subjects a broad range of transactions to the review of the CAB, and section 414, which immunizes from the antitrust laws those transactions approved by the Board. This Court, noting that "the parent company which controls an air carrier is subject to pervasive control by the CAB" (*id.* at 387), concluded that the challenged acts were under the CAB's control and surveillance, and were therefore immune under the antitrust laws.

Obviously, this case bears little similarity to those cases. There, immunity was implied because the application of the antitrust laws would have conflicted with the efforts of regulatory agencies charged with pervasive regulatory authority. In contrast, the Planning Act creates *no* federal regulatory agency with *any* regulatory authority over Blue Cross or BCA, much less a "pervasive regulatory scheme." Most importantly, no public agency has any authority under the Act to approve or authorize any business conduct by Blue Cross or BCA, much less a clearly anticompetitive group boycott otherwise in violation of the antitrust laws. As in *Silver*, a conclusion that the antitrust laws had been impliedly repealed would "defeat the Congressional policy reflected in the antitrust laws" (373 U.S. at 360) without serving any federal regulatory policy.

CONCLUSION

The judgment of the court below should be reversed.

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NATIONAL GERIMEDICAL HOSPITAL
and GERONTOLOGY CENTER,

Petitioner,

—v.—

BLUE CROSS OF KANSAS CITY and
BLUE CROSS ASSOCIATION,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE EIGHTH CIRCUIT

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QUESTION PRESENTED

The National Health Planning and Resources Development Act of 1974 directs federally designated Health Systems Agencies to prepare regional Health Systems Plans to regulate hospital construction, and to "implement" these Plans in cooperation with private health care insurance providers such as Blue Cross.

In this case, a hospital was constructed in disregard of a determination by a Health Systems Agency, acting under authority of the Health Planning Act, that additional hospital beds in its area were unnecessary. The hospital applied to Blue Cross for a reimbursement contract; Blue Cross, allegedly in concert with the Health Systems Agency and others, adhered to its policy of contracting only with hospitals that had been granted the Health Systems Agency's approval, thereby implementing the Health Systems Plan.

The question presented is whether the Health Planning Act of 1974 impliedly repealed the antitrust laws with respect to this specific conduct.

TABLE OF CONTENTS

	PAGE
Statutory Provisions Involved	1
Statement of the Case	2
Summary of Argument	8
Argument	10
I. Congress Intended the Health Planning Act of 1974 to Halt the Overbuilding of Hospital Beds	10
A. The Problem of Overbedding in 1974	10
B. Congress Intended Planning to Prevent Duplication of Health Resources	12
C. Reliance by the Solicitor General on the History and Language of the 1979 Act Is Misplaced	17
II. Congress Intended to Implement the Health Planning Act of 1974 Through Cooperation by Private Entities	24
A. Cooperation by Private Entities in Implementing the Health Systems Plan Was Essential to the Statutory Scheme	24
B. The Enactment of State Certificate of Need Legislation Did Not Supplant Implementation Through Cooperation by Private Entities	28
III. Repeal of the Antitrust Laws Should Be Implied in the Circumstances of this Case Because of the Irreconcilable Conflict Between Anticompetitive Inpatient Hospital Planning and Competition	32

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PAGE

IV. The Inclusion of an Exemption for Individual Liability in the Health Planning Act of 1974 Has Nothing to Do With Finding an Implied Repeal of Antitrust Here 43

Conclusion 47

Appendix 1a

TABLE OF AUTHORITIES

CASES: PAGE

Alabama Power Co. v. *Alabama Electric Cooperative, Inc.*, 394 F.2d 672 (5th Cir.), *cert. denied*, 393 U.S. 1000 (1968) 45

American Medical Association v. *United States*, 317 U.S. 519 (1943) 40 n.29

Andrus v. *Shell Oil Co.*, 446 U.S. 657 (1980) 23 n.17

Associated Press v. *United States*, 326 U.S. 1 (1945) ..40 n.29

Cain v. *Air Cargo, Inc.*, 599 F.2d 316 (9th Cir. 1979) .45 n.35

California v. *Federal Power Commission*, 369 U.S. 482 (1962) 38-39

California Retail Liquor Dealers Association v. *Midcal Aluminum, Inc.*, 445 U.S. 97 (1980) 35 n.27

Carnation Co. v. *Pacific Westbound Conference*, 383 U.S. 213 (1966) 45 n.35

Champaign-Urbana News Agency Inc. v. *J.L. Cummins News Co.*, 632 F.2d 680 (7th Cir. 1980)..... 46

City of Lafayette v. *Louisiana Power & Light Co.*, 435 U.S. 389 (1978) 35 n.27

Fashion Originators Guild v. *FTC*, 312 U.S. 457 (1941) ...39, 39-40 n.29

Federal Maritime Commission v. *Seatrain Lines, Inc.*, 411 U.S. 726 (1973) 45 n.35

Goldfarb v. *Virginia State Bar*, 421 U.S. 773 (1975) ..35 n.27, 43 n.32, 45

Gordon v. *New York Stock Exchange, Inc.*, 422 U.S. 659 (1975) 8, 9, 32, 35 n.27, 36-37, 40-41, 42

Group Life & Health Insurance Co. v. *Royal Drug Co., Inc.*, 440 U.S. 205 (1979) 43 n.32, 45

PAGE

Hospital Building Co. v. *Trustees of Rex Hospital*, 425 U.S. 738 (1976) 43 n.32, 45

Hughes Tool Co. v. *Trans World Airlines*, 409 U.S. 363 (1973) 34

Nankin Hospital v. *Michigan Hospital Service*, 361 F. Supp. 1199 (E.D. Mich. 1973) 43 n.32

Nashville Milk Co. v. *Carnation Co.*, 355 U.S. 373 (1958) 23 n.17

Northern Pacific Railway Co. v. *United States*, 356 U.S. 1 (1958) 32, 37-38

Otter Tail Power Co. v. *United States*, 410 U.S. 366 (1973) 39 n.29

Pan American World Airways, Inc. v. *United States*, 371 U.S. 296 (1963) 34, 46

Parker v. *Brown*, 317 U.S. 341 (1943) 30 n.23

Regional Rail Reorganization Cases, 419 U.S. 102 (1974) ... 23 n.17

Silver v. *New York Stock Exchange*, 373 U.S. 341 (1963) ... 34, 39 n.29

Travelers Insurance Co. v. *Blue Cross of Western Pennsylvania*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973) 43 n.32

United States v. *Borden Co.*, 308 U.S. 188 (1939) 45 n.35

United States v. *National Association of Securities Dealers, Inc.*, 422 U.S. 694 (1975) ... 8, 9, 32-36, 37, 42, 46

United States v. *Philadelphia National Bank*, 374 U.S. 321 (1963) 23 n.17, 39

United States v. *Radio Corporation of America*, 358 U.S. 334 (1959) 38

United States v. *Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940) 39 n.29

PAGE

United States v. *United Mine Workers,* 330 U.S. 258 (1947) 22 n.17

Westinghouse Electric Corp. v. *Gulf Oil Corp.,* 588 F.2d 221 (7th Cir. 1978) 38 n.28

STATUTES:

Communications Act of 1934, 47 U.S.C. § 309..... 39

Federal Aviation Act, 49 U.S.C. § 1384 39

Interstate Commerce Act, 49 U.S.C. § 10706 39

Investment Company Act of 1940, 15 U.S.C. §§ 80a *et seq.* 32-34

Mo. Ann. Stat. ¶¶ 197.300 *et seq.* (Vernon Supp. 1980). .6 n.6

Mo. Rev. Stat. §§ 354.010 *et seq.* 4 n.3

National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300k *et seq.* ..... *passim*

Sherman Act, §§ 1, 2, 15 U.S.C. §§ 1, 2 ..... 1, 7

Social Security Act, § 1122, 42 U.S.C. § 1320a-1 ....6 n.6, 14

2 U.S.C. § 170(c) 44 n.33

15 U.S.C. § 78kkk(c) 44 n.33

19 U.S.C. § 1513..... 44 n.33

40 U.S.C. § 489(a) 44 n.33

42 U.S.C. § 300j-6(a)..... 44 n.33

Comprehensive Health Planning and Public Health Services Amendments of 1966, Pub. L. No. 89-749, 80 Stat. 1180..... 13, 24

Hospital and Medical Facilities Amendments of 1964, Pub. L. No. 88-443, 78 Stat. 447..... 13

PAGE

MISCELLANEOUS:

CHAYET & SONNENREICH, P.C., CERTIFICATE OF NEED: AN EXPANDING REGULATORY CONCEPT (1978) 6 n.6

Rogatz, *Excessive Hospitalization Can be Cut Back,* 48 HOSPITALS 51 (1974) 11 n.8

Shain & Roemer, *Hospital Costs Relate to the Supply of Beds,* 92 MOD. HOSPITALS 71 (1959).....11 n.8

WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY (1971) 30 n.24

National Health Planning and Development Act, 1974: Hearings on S. 2994, S. 3139, S. 2796 and Related Bills Before the Subcommittee on Health of the Committee on Labor and Public Welfare, 93d Cong., 2d Sess. (1974) 31 n.25

S. Rep. No. 93-1285, 93d Cong., 2d Sess., *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842....11-13, 14, 18 n.12, 25, 26, 32

S. Rep. No. 96-96, 96th Cong., 1st Sess., *reprinted in* [1979] U.S. Code Cong. & Ad. News 1306 .....22 n.15, 26

S. Rep. No. 96-309, 96th Cong., 1st Sess. (1979) 21

H. Rep. No. 2519, 79th Cong., 2d Sess., *reprinted in* [1946] U.S. Code Cong. & Ad. News 1558..... 13

H. R. Rep. No. 96-420, 96th Cong., 1st Sess., *reprinted in* [1979] U.S. Code Cong. & Ad. News 1422 21

Cong. Rec.....13, 19, 23, 26, 30

No. 80-802

IN THE

Supreme Court of the United States

October Term, 1980

NATIONAL GERIMEDICAL HOSPITAL
and GERONTOLOGY CENTER,

Petitioner,

—v.—

BLUE CROSS OF KANSAS CITY and
BLUE CROSS ASSOCIATION,

Respondents.

BRIEF FOR RESPONDENTS

This brief is submitted on behalf of respondents Blue Cross of Kansas City and Blue Cross Association.

STATUTORY PROVISIONS INVOLVED

The statutes involved in this case are set forth in the Appendix at the end of this brief. These include Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2, and certain provisions of the National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300k *et seq.* The 1974 Act, the statute involved in this case, was amended in 1979. Pub. L. No. 96-79, 93 Stat. 592.

STATEMENT OF THE CASE

In 1974 this country was confronted with the problem of "overbedding"—a surplus of hospital beds. The high cost of maintaining excess beds (or "inpatient" facilities, as hospital beds are commonly termed) was determined to be a chief contributor to the burgeoning inflation in the cost of health services. In response, Congress enacted the National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225, 42 U.S.C. §§ 300k *et seq.* (the "Health Planning Act of 1974"), to prevent the "unnecessary duplication of health resources" and, specifically, the construction of duplicative inpatient facilities. This duplication was deemed by Congress to increase the cost of health services.

The 1974 Act authorized creation of federally designated and funded Health Systems Agencies ("HSAs"), each of which was charged with developing a regional Health Systems Plan to serve as a blueprint for future development by all participants in the local health care community. 42 U.S.C. § 300*l*-2(b). Each HSA was directed to "implement its [Health Systems Plan] with the assistance of individuals and public and private entities in its health service area." 42 U.S.C. § 300*l*-2(c)(1).

In 1976, Mid-America Health Systems Agency ("MAHSA") was conditionally designated by the Secretary of Health, Education and Welfare (now Health and Human Services) as the HSA for the region encompassing metropolitan Kansas City. (J.A. 202a-03a).[1] MAHSA is a federally funded not-for-profit corporation. (J.A. at 34a; 42 U.S.C. § 300*l*-5). As required by the Health Planning Act of 1974, its board of directors represents a broad cross-section of the community, consisting of consumers of health care and "providers," including hospi-

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1 As used herein, "J.A." refers to the Joint Appendix; "D.R." refers to the Designated Record on Appeal; "Pet. Br." refers to the petitioner's brief; "S.G. Br." refers to the brief of the United States as *amicus curiae*; "F.A.H. Br." refers to the brief of the Federation of American Hospitals as *amicus curiae*.

tals and third-party payers such as Blue Cross Plans. 42 U.S.C. § 300*l*-1(b)(3)(C)(i),(ii)(III). Congress found that since the provider is "one of the most important participants" in the health care sector, "it is *imperative* that the provider be encouraged to play an active role in developing health policy *at all levels.*" 42 U.S.C. § 300k(a)(5) (emphasis added).

Pursuant to its statutory responsibilities, MAHSA developed a Health Systems Plan ("HSP"), which was formally adopted as the five-year plan for the region in 1977. (Relevant sections of the HSP are reproduced in the Joint Appendix at pages 27a-134a.) In the HSP, as "a number one priority for implementation," MAHSA stressed the need to find a solution to the growing surplus of hospital beds in the Kansas City area. (J.A. at 105a). MAHSA found that existing inpatient facilities already were meeting the needs of the community, and that by 1983 the region would have as many as 2,420 surplus beds. (J.A. at 84a-85a; 102a).

The cost of maintaining empty beds was translated into dollars in the Health Systems Plan:

> "A staffed, but unused hospital bed costs the hospital to maintain. . . . The total cost to the community for the projected surplus beds could range from $31,097,150 to as high as $93,484,600 annually by 1983—the equivalent of $22 to $67 per capita in the MAHSA area." (J.A. at 89a).

This lack of use, however, constituted only part of the cost. Efforts by Kansas City hospitals to fill their surplus beds were anticipated by MAHSA to lead to "inappropriate admissions," as well as unnecessarily long stays, resulting in added expense, and, worse, in needless risk to patients:

> "The cost of over-utilization is measured by more than just the cost of the hospital stay. The total cost includes the possibility of increased morbidity [the relative incidence of disease] and mortality in addition to social and emotional costs." (J.A. at 90a).

Significantly, "the use rate and admission rate" in Kansas City "were among the highest in the United States." (J.A. at 89a).

On the basis of these findings, MAHSA determined that it was unnecessary to add to the hospital beds available in the Kansas City area and "publicly declared that it would disapprove the addition of any additional acute care hospital beds." (Pet. Br. at 5).[2]

MAHSA also determined that since the cost of inpatient services was influenced by the "nature of third party reimbursement programs" such as Blue Cross, these programs should "promote appropriate utilization of hospital services." (J.A. at 66a-67a). MAHSA stated that its "Plan should be used by community leaders as a decision making tool for the allocation of local public and private health care resources," recognizing that "without the assistance, involvement and willing participation" of consumers, providers and others, "no Health Systems Plan, no matter the quality, will be implemented." (J.A. at 43a, 40a).

Respondent Blue Cross of Kansas City ("Blue Cross") was one of the participants in MAHSA, with representation on MAHSA's board. Blue Cross is a non-profit organization, organized pursuant to Missouri law and subject to the supervision of the Missouri Director of Insurance.[3] It offers individual and group health care reimbursement plans to the general public in Missouri and Kansas. (Complaint ¶ 4, J.A. at 7a). A majority of its board and its executive committee are representatives of the public, including community, business and labor leaders. (Blue Cross Int. Ans., Exhibit A; D.R. at 270). According to the petitioner, Blue Cross subscribers account for

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2 "Acute care" services include medical/surgical services, obstetrics, pediatrics, and acute psychiatric and alcohol beds. (J.A. at 65a). They do not include long-term services such as those provided by nursing homes. (J.A. at 58a-59a).

3 Mo. Rev. Stat. §§ 354.010 *et seq.*

"approximately one-fourth of all area hospital admissions" in the Kansas City region. (Pet. Br. at 4).[4]

Reimbursement made for hospital services provided to Blue Cross subscribers is paid directly by Blue Cross to hospitals with which Blue Cross has entered into contracts. These are known as "participating hospitals." (Complaint ¶ 13, J.A. at 9a). (When Blue Cross subscribers are treated at other hospitals, the subscriber pays the hospital and Blue Cross reimburses the subscriber at 80 percent of the hospital's charges. *Id.*)

On January 1, 1976, Blue Cross had adopted the following policy for contracting with new hospitals, adhering precisely to the findings of local planning agencies:

> "The hospital must meet a clearly evident need for health care services in its defined service area. *Health care institutions and institutional services shall be approved,* and/or if required by law, certified as necessary, *by the designated planning agency or areawide health planning agency respectively;* or, when effective, by the designated State Agency as provided for in Public Law 93-641, the 'National Health Planning and Resources Development Act of 1974.' " (J.A. at 146a) (emphasis added).

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4 The other respondent, Blue Cross Association ("BCA"), is an Illinois not-for-profit membership corporation to which Blue Cross Plans throughout the United States belong. (BCA Aff., ¶ 2; D.R. at 39). BCA does not do business in Missouri and does not offer health care plans in Missouri or elsewhere; it does not contract with hospitals. (*Id.*, ¶¶ 3, 4, 7; D.R. at 39-40). Blue Cross is a member of BCA, but BCA has neither the power nor the duty to control Blue Cross' contracts with any hospital. (BCA Aff., ¶ 4; BCA Int. Ans., Exhibits E & F; D.R. at 39). The statement of purpose in BCA's Articles of Incorporation specifies that "inherent in [BCA's] purposes is a recognition that State and local Plans are, and should be, autonomous in their operation and that the needs, facilities, resources and practices of the respective areas shall be given due consideration." (BCA Aff., ¶ 3; D.R. at 39). BCA also formulates guidelines to advise the local Plans as to cost containment approaches. (*See* J.A. at 159a-166a).

And, on July 21, 1976, recognizing that Missouri had no state-level planning agency at that time, Blue Cross publicly had announced:

> "Since the State Planning Agency no longer exists, Blue Cross of Kansas City will look to the local Health Systems Agency for approval of . . . capital projects. That Health Systems Agency in the Kansas City metropolitan area is the Mid-America Health Systems Agency. . . . *All projects not reviewed and approved by these Health Systems Agencies will not be reimbursable by Blue Cross of Kansas City.*" (J.A. at 204a).[5]

Disregarding MAHSA's determination in the Health Systems Plan against adding new hospital beds, the petitioner, National Gerimedical Hospital and Gerontology Center ("National Gerimedical"), proceeded to erect a new 120-bed acute care hospital in metropolitan Kansas City. (Complaint ¶ 3, J.A. at 6a). It did not ask MAHSA to reconsider or to make an exception in its case; petitioner neither sought nor received MAHSA's approval. (Pet. Br. at 5).[6]

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5 This policy of Blue Cross was also applicable to projects undertaken by existing hospitals.

6 National Gerimedical took advantage of a unique hiatus which arose for a few years after 1976 when Missouri, which had not yet enacted a state certificate of need law, decided not to renew its contract with HEW under Section 1122 of the Social Security Act. 42 U.S.C. § 1320a-1.

In August 1979 (effective October 1, 1980), Missouri adopted certificate of need legislation, which now effectively bars the construction of new hospitals that have not been approved by the state planning agency. Mo. Ann. Stat. ¶¶ 197.300 *et seq.* (Vernon Supp. 1980). Nationwide, every other state also has passed certificate of need laws restricting construction of unapproved hospitals, except for Louisiana. *See* CHAYET & SONNENREICH, P.C., CERTIFICATE OF NEED: AN EXPANDING REGULATORY CONCEPT 155-944 (1978). Accordingly, the opportunity to build an unnecessary hospital was not only short-lived in Missouri, but now has been legislated against in virtually the entire country.

On February 16, 1978, National Gerimedical applied to Blue Cross for a participating hospital contract. (Complaint ¶ 16, J.A. at 10a). Blue Cross adhered to its policy of contracting with new hospitals only if MAHSA had approved the additional facilities and, on March 21, 1978, informed National Gerimedical that its application had been denied. (Complaint ¶ 17, J.A. at 10a). National Gerimedical proceeded to open seven months later, on October 16, 1978. (Pet. Br. at 3).[7]

National Gerimedical brought this suit on May 23, 1978 in the United States District Court for the Western District of Missouri, charging defendants Blue Cross and the Blue Cross Association with conspiring with MAHSA and others to refuse to contract with National Gerimedical, thereby placing that hospital at a competitive disadvantage in violation of Sections 1 and 2 of the Sherman Act. The district judge granted summary judgment, dismissing the complaint on the ground that the Health Planning Act of 1974 impliedly repealed the federal antitrust laws. (J.A. at 171a, 192a). The United States Court of Appeals for the Eighth Circuit unanimously affirmed and denied rehearing. (J.A. at 199a, 217a). National Gerimedical then petitioned this Court for a writ of certiorari, which was granted on January 26, 1981.

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7 Amicus complains that Blue Cross barred the hospital's entry. (S.G. Br. at 13). This is not the case. Having successfully sidestepped the 1974 Act's planning process and erected a 120-bed hospital during the hiatus in Missouri law, petitioner here seeks, with the aid of the antitrust laws, to force Blue Cross to contract to help to pay for those beds.

SUMMARY OF ARGUMENT

The jugular issue is one of congressional intent at the time the Health Planning Act of 1974 was passed; that is, whether Congress intended the actions challenged in this case to be subject to the antitrust laws. Repeal of the antitrust laws should be implied where a subsequently enacted regulatory scheme is irreconcilable with antitrust, and repeal of antitrust is necessary to make the scheme work. *United States* v. *National Association of Securities Dealers, Inc.*, 422 U.S. 694 (1975); *Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659 (1975).

The intent of Congress in enacting the Health Planning Act of 1974—the legislation relevant to this private case—was shaped by concern over the thousands of excess hospital beds being built in the United States and the failure of classic marketplace forces to prevent or correct the situation. Skyrocketing costs, wasteful duplication of resources and unnecessary capital expenditures presented the chief problems. To view the matter as did the 1974 Congress is to understand that preventing unnecessary duplication of hospital beds was of the highest priority.

Congress responded with comprehensive planning, coordinated by federally designated and funded Health Systems Agencies ("HSAs"). Federally supervised areawide planning was first introduced, on a less ambitious scale, in the mid-1960's. In adopting the Health Planning Act of 1974 Congress confirmed that planning, rather than competition, should allocate the nation's supply of hospital beds to avoid needless and costly duplication.

The HSAs were directed to formulate regional plans and "to implement [these plans] with the assistance of individuals and public and private entities. . . ." 42 U.S.C. § 300*l*-2(c)(1). Cooperative implementation by private entities was basic to the Health Planning Act of 1974, and Congress intended such

implementation to be encouraged. While other approaches for controlling the overbuilding of hospitals developed, including state certificate of need programs, these approaches were complementary to cooperative implementation by private entities, not substitutes for it.

The comprehensive planning mandated for preventing duplication of hospital facilities is the antithesis of competition, and as a consequence, the Health Planning Act of 1974 is at loggerheads with antitrust. Moreover, the cooperative implementation specified by the 1974 Health Planning Act cannot succeed if the private entities which are expected to do the implementing are faced with the conflicting standards of planning and antitrust, and with exposure to antitrust treble damage liability. It was precisely to avoid such results that the doctrine of implied repeal was fashioned, and under the principles of implied repeal articulated in *NASD* and *Gordon,* the antitrust laws must give way.

Here, the very conduct under attack as an antitrust violation is integral to the design of Congress in framing the 1974 Act. Congress required the formulation of Health Systems Plans "preventing unnecessary duplication" and instructed the HSA's "to implement [these plans] with the assistance of individuals and public and private entities. . . ." 42 U.S.C. § 300*l*-2(a)(4), (c)(1). The HSA here determined in its Plan that no additional hospital beds should be opened in the area and called upon insurers such as Blue Cross to implement that Plan. The Complaint charges that "Blue Cross and BCA have combined, contracted and conspired with each other and with co-conspirator MAHSA" and others: "(i) to deny plaintiff hospital Blue Cross Participating Membership . . . and (ii) to limit, restrict and foreclose plaintiff's entry . . . ." (Complaint ¶ 18(e), J.A. at 12a). Thus, the conduct alleged to violate the antitrust laws is the very conduct specified by the 1974 Health Planning Act, and implied repeal is necessary to make the Act work.

It is no answer to say that the conduct here was "unsupervised," because the determination by Blue Cross precisely

followed the determinations of a federally established and funded HSA. Blue Cross adopted no community need standards; it merely followed the decisions made by the HSA. It is also erroneous to suggest that respondents are seeking a "blanket" or "umbrella" exemption. The only issue is whether implied repeal of antitrust under the 1974 Act should be found on the specific facts of this case.

Moreover, inclusion of a liability exemption in the 1974 Act for individuals serving on an HSA does not preclude the finding of an implied repeal under the doctrine of "expressio unius." The exemption had nothing to do with antitrust—the 1974 Congress had no reason to consider antitrust—and implied repeals have been found by this Court despite specific exemptions which did not cover the conduct in question.

The overriding issue here is, necessarily, the congressional intent in the 1974 Act, as applied to the specific facts of this case. That intent of Congress in 1974 was to prevent unnecessary duplication of hospital facilities through planning, relying on cooperative implementation by private parties. Had the 1974 Congress addressed the specific facts of this case, it would have thoroughly approved the action of Blue Cross, which precisely followed the HSA's determination.

ARGUMENT

I.

Congress Intended the Health Planning Act of 1974 to Halt the Overbuilding of Hospital Beds

A. The Problem of Overbedding in 1974

The Health Planning Act of 1974 begins with, and is based on, a congressional finding that "[i]ncreases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary. . . ." 42 U.S.C. § 300k(a)(4). Since this case necessarily turns on the intent of Congress in 1974, it is important to return to the perspective of that year and examine the situation faced by the Congress. Congressional investigation at the time revealed that:

> "Investment in costly health care resources, such as hospital beds . . . is frequently made without regard to the existence of similar facilities or equipment already operating in an area. Investment in costly facilities and equipment not only results in capital accumulation, but establishes an ongoing demand for payment to support those services. There is convincing evidence from many sources that overbuilding of facilities has occurred in many areas, and that maldistribution of high cost service exists." S. Rep. No. 93-1285, 93d Cong., 2d Sess. 39, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7878.

The "ongoing demand for payment" to support excess facilities was causing surplus beds to be filled unnecessarily, either by admitting patients who did not genuinely need to be hospitalized or by holding other patients in hospitals longer than medically warranted. Demand was being artificially inflated to meet supply, encouraging the supply of beds to expand continuously under a sort of medical Parkinson's law, which has become known as Roemer's Law.[8] As described above, this was identified in the MAHSA Health Systems Plan as a particular problem in Kansas City, where usage and admission rates were unusually high. (*See* p.4 *supra*).

Congress found that there would be nearly 67,000 excess hospital beds in this country, according to 1974 estimates. S. Rep. No. 93-1285, 93d Cong., 2d Sess. 24, 42, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7864, 7882. As elaborated in the Senate Report:

> "Hospital beds, though unused, contribute substantial additional costs to the health care industry. It is estimated that a hospital bed, full or empty, costs ⅓ its initial cost each year to operate. Each $1,000 invested in hospital

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8 *See* Shain & Roemer, *Hospital Costs Relate to the Supply of Beds*, 92 Mod. Hospitals 71 (1959); Rogatz, *Excessive Hospitalization Can be Cut Back*, 48 Hospitals 51, 52 (1974).

> expansion requires approximately $333 each year in operational financing." S. Rep. No. 93-1285, 93d Cong., 2d Sess. 39, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7879.

In 1974, it was projected that the total annual expense of supporting excess hospital beds in America would reach between $1 and $2 billion per year. *Id.* at 42, *reprinted at* 7882.

Examining the reasons for this surplus, the Senate Committee found in 1974:

> "The need for strengthened and coordinated planning for personal health services is growing more apparent each day. In the view of the Committee *the health care industry does not respond to classic marketplace forces.* The highly technical nature of medical services together with the growth of third party reimbursement mechanisms act to attenuate the usual forces influencing the behavior of consumers with respect to personal health services. For the most part, the doctor makes purchasing decisions on behalf of the patient and the services are frequently reimbursed under health insurance programs, thus reducing the patient's immediate incentive to contain expenditures." *Id.* at 39, *reprinted at* 7878 (emphasis added).

To overcome these factors and end overbedding, Congress enacted the Health Planning Act of 1974.

B. Congress Intended Planning to Prevent Duplication of Health Resources

The purpose and design of the Health Planning Act of 1974 are illuminated when viewed in historical context.

At the conclusion of the Second World War, Congress found that the United States was suffering from a serious shortage of hospital beds resulting from a virtual suspension of hospital building during the Depression and the War. S. Rep. No. 93-1285, 93d Cong., 2d Sess. 19, *reprinted in* [1974] U.S. Code

Cong. & Ad. News 7842, 7859. The House Committee on Interstate and Foreign Commerce concluded that the free market development of hospital services "resulted not in a system of hospital and health facilities, but in a pattern leaving many areas of unmet need." H. Rep. No. 2519, 79th Cong., 2d Sess. 4, *reprinted in* [1946] U.S. Code Cong. & Ad. News 1561. To remedy the situation, Congress enacted the Hill-Burton Program in 1946 to underwrite new hospital construction with federal assistance. *Id.* So much construction was undertaken, however, that by the mid-1960's Congress discovered that too many hospital beds were being built. 110 Cong. Rec. 11790 (1964) (remarks of Rep. Harris); 112 Cong. Rec. 24707 (1966) (remarks of Sen. Kennedy).

To combat this, new legislation was enacted beginning in 1964. The Hospital and Medical Facilities Amendments of 1964, Pub. L. No. 88-443, 78 Stat. 447, and the Comprehensive Health Planning and Public Health Services Amendments of 1966, Pub. L. No. 89-749, 80 Stat. 1180, introduced the concept of federally coordinated regional planning. The 1964 law authorized federal funding for areawide health facilities planning councils to oversee new hospital construction. 78 Stat. at 452 § 604. The 1966 Act, which opened with the declaration that "comprehensive planning for health services . . . is essential" to achievement of national health goals, coordinated both construction and a broader range of health planning through the creation of areawide and state comprehensive health planning ("CHP") agencies. 80 Stat. at 1181 § 2(b).

Meanwhile, in the late 1960's, some states began to experiment with certificate of need laws. These laws restricted new hospital construction unless approved by a specified state agency. In states where such laws were adopted, areawide CHP agencies assumed the additional responsibility of reviewing proposals for new facilities on behalf of the state agencies involved. S. Rep. No. 93-1285, 93d Cong., 2d Sess. 10, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7852.

As for the federal government, in 1972, Congress amended the Social Security Act to prohibit the use of Medicare and Medicaid funds to reimburse health care facilities for costs associated with capital expenditures which did not meet with agency approval. Pub. L. No. 92-603, § 221(a), 86 Stat. 1329 at 1386, codified at 42 U.S.C. § 1320a-1. With this addition, the goals of planning could be achieved in three ways: through cooperative implementation by hospitals, insurers and other providers, which was the chief means of implementation originally contemplated under the 1966 Act (*see* pp. 24-25 *infra*); through the emerging state certificate of need programs; and through the denial of Medicare and Medicaid funding under the Social Security Act.

After several years of operation, the various laws were reviewed by Congress and crystallized into the Health Planning Act of 1974. Pub. L. No. 93-641, 88 Stat. 2225, codified at 42 U.S.C. § 300k *et seq.* Congress sought to build "upon the experience of these programs and . . . to combine their best features into one new health planning and resources development effort." S. Rep. No. 93-1285, 93d Cong., 2d Sess. 5, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7846.

Congress determined in 1974 that "[t]he need for additional hospital beds in the nation [had] virtually disappeared." *Id.* at 24, *reprinted at* 7864. It recognized that competition had been ineffective in the health care sector, and in place of the "classic marketplace forces" which did not work, it framed a new, even more comprehensive "national health planning policy." 42 U.S.C. § 300k(b). The principal actors in the new scheme were the regional, federally designated and funded Health Systems Agencies ("HSAs"). *Id.* at §§ 300*l*-300*l*-5. Each HSA was charged with responsibility for the "provision of effective health planning for its health service area and the promotion of the development within the area of health services, manpower, and facilities which meet identified needs, reduce documented inefficiencies, and implement the health plans of the agency." *Id.* at § 300*l*-2(a). Each was also expected to meet the goals of "restraining increases in the cost of providing . . . health

services" and "preventing unnecessary duplication of health resources." *Id.* at § 300*l*-2(a)(3), (4). Nowhere in the 1974 Act was there *any* congressionally stated goal of encouraging competition in the health services field.

To achieve these specified objectives, each HSA was directed to formulate a master Health Systems Plan ("HSP") and Annual Implementation Plans ("AIPs") for its region.[9] 42 U.S.C. at § 300*l*-2(b). An HSP is a detailed statement of goals describing the type of environment and health systems which will assure the area economical, accessible and high quality health services. *Id.* These goals must be responsive to the needs and resources of the area and must be consistent with national guidelines for health planning policy. *Id.*[10]

Furthermore—and most important in this case—Congress stated that:

> "A health systems agency shall implement its HSP and AIP, and *in implementing the plans* it shall perform at least the following functions:
>
> "(1) The agency shall seek, to the extent practicable, *to implement* its HSP and AIP *with the assistance of individuals and public and private entities* in

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9 AIPs are specific yearly objectives for achieving the goals of the HSP. 42 U.S.C. § 300*l*-2(b)(3).

10 Specifically, in promulgating a Health Systems Plan, the HSA is required to assemble and analyze data concerning the status of health and health care in its area; the number, type and location of health care facilities, and the patterns of utilization of these facilities; and the effect of the area's health care delivery system on the health of area residents. 42 U.S.C. § 300*l*-2(b) (1). In formulating its Health Systems Plan, the HSA is required to consider the recommended national guidelines for health planning policy issued by the Secretary of Health and Human Resources, the priorities set forth in the Health Planning Act, and the data which it was required to assemble. 42 U.S.C. § 300*l*-2(b)(2). Before establishing its Health Systems Plan, each HSA is required to conduct a public hearing and give interested persons an opportunity to submit their views orally and in writing. *Id.* All of the activities of the HSA are subject to continuous review by the United States Department of Health and Human Services. 42 U.S.C. § 300*l*-4.

its health service area." *Id.* at § 300*l*-2(c)(1) (emphasis added).[11]

Congress conferred general supervisory authority over the HSAs upon the Secretary of Health, Education and Welfare (now Health and Human Services). The Secretary was required to issue guidelines and goals concerning national health planning policy, 42 U.S.C. § 300k-1, to enter into agreements designating entities as HSAs, and to revoke such designation if an HSA failed to comply with or effectively carry out the provisions of its agreement. *Id.* at § 300*l*-4.

The 1974 Act requires a careful review and extensive scrutiny of any entity before the Secretary can enter into an agreement and thereby designate it as an HSA. The Act contains three requirements which must be met before a conditional designation is made:

> "(A) the entity has submitted an application for such designation which contains assurances satisfactory to the Secretary that upon completion of the period of conditional designation the applicant will be organized and operated in the manner described in section 300*l*-1(b) of this title and will be qualified to perform the functions prescribed by section 300*l*-2 of this title;
>
> "(B) a plan for the orderly assumption and implementation of the functions of a health systems agency has been

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11 Also, in another section, 42 U.S.C. § 300*l*-2(d), Congress provided that:

> "Each health systems agency shall coordinate its activities with—
>
> . . .
>
> "(5) any other appropriate entity,
>
> in the health system agency's health service area. The agency shall, as appropriate, secure data from them for use in the agency's planning and development activities, enter into agreements with them which will assure that actions taken by such entities which alter the area's health system will be taken in a manner which is consistent with the HSP and the AIP in effect for the area, and, to the extent practicable, provide technical assistance to such entities."

received from the applicant and approved by the Secretary; and

"(C) the Secretary has consulted with the Governor of each State in which such health service area is located and with such other State and local officials as he may deem appropriate with respect to such designation." *Id.* at § 300*l*-4(b)(4).

At the state level, the 1974 Act provided, in *another* section, for the designation of State Health Planning and Development Agencies ("SHPDAs") to develop state health plans in coordination with Statewide Health Coordinating Councils and to administer state certificate of need programs, where they existed, under guidance from the HSAs. *Id.* at § 300m-300m-5. (The relevance here of state certificate of need programs is discussed *infra* at pp. 28-30.)

What Congress accomplished in the Health Planning Act of 1974 was the creation of a comprehensive mechanism to prevent duplication in the allocation of this nation's health care resources through coordinated planning.

C. Reliance by the Solicitor General on the History and Language of the 1979 Act Is Misplaced

The brief for the United States, as *amicus curiae,* attempts to obscure the issue in this case—the intent of the 1974 Health Planning Act—by focusing instead on the 1979 Act, Pub. L. No. 96-79, 93 Stat. 592, adopted after this case arose, and, therefore, not applicable here. Rather than conducting its analysis from the perspective of 1974, as it must on the facts of this case, the Solicitor General relies on language from the 1979 Act, which he properly notes is "the only statutory language that specifically refers to competition." (S.G. Br. at 16-17).

The Solicitor General's reliance on the 1979 Act is erroneous on two grounds. First, the issue here is the intent of Congress in the 1974 Act, not in the 1979 Act. Second, even if, for the

sake of argument, the 1979 Act is considered relevant, it clearly supports, both on its face and in the accompanying debates and reports, *respondents'* position that in 1974 Congress intended planning, not competition, to allocate the supply of inpatient hospital services. The language and legislative history of the 1979 Act confirm that the 1974 Act was irreconcilable with competition.

At the time the 1979 Act was being considered, concern was expressed in Congress that, in the case of health programs in which providers of care are prepaid for services furnished to enrollees, notably Health Maintenance Organizations ("HMOs"), and in the case of *outpatient* facilities,[12] competitive forces could work. Congress was therefore willing in 1979 to promote competition—*a new concept*—for such programs. In discussing the proposed 1979 Act, Representative Gramm, a member of the Subcommittee on Health and the Environment, expanded on this dichotomy:

> "One of the most important *innovations* is the *creation of competition* in the health care market. We tolerate planning in the health care market, because we have a system which, because of third-party payments, makes the buyer nonprice conscious. This, therefore, creates, on the supply side, nonprice competition, nonconcern about duplication and expense. *We, therefore, have imposed a comprehensive set of controls to prevent duplication.*
>
> "One of the most important things that we have done in these amendments is to recognize that *in a prepaid plan,* whether it is an HMO or simply a vendor of care who is licensed by a State and selling on a prepaid basis, once he sells a contract to provide a service, all of our standard market forces work in his case and, therefore, there is no reason to control him. There is no justification for limit-

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12 "The term 'outpatient facility' means a health facility which offers a reasonably full range of diagnostic and treatment services, not including bed and board." S. Rep. No. 93-1285, 93d Cong., 2d Sess. 59, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7898.

> ing his access to equipment and capital and, under these amendments, we help promote *in this area, which has been devoid of competitive forces in the past, a new competition* which can give us the vehicle to some day let free enterprise work again in the health care market." 125 Cong. Rec. H6219 (daily ed. July 19, 1979) (emphasis added).

Representative Waxman, the Chairman of the Subcommittee, referred to Representative Gramm's proposal in 1979 to exempt HMOs from planning approval (now 42 U.S.C. § 300m-6(b)), and remarked:

> "It is, I think *a new thrust* in the approach to health planning, and . . . an indication of *desire . . . to develop some competition,* some market forces in the health care system where so few are now present." 125 Cong. Rec. H6219 (daily ed. July 19, 1979) (emphasis added).

Thus, in drafting the 1979 Act, Congress drew a clear distinction between inpatient services and prepaid or outpatient services. It fashioned a general provision, now 42 U.S.C. § 300k-2(b), which, in its three paragraphs, introduced encouragement of competition, where it could work, for HMOs and outpatient programs. At the same time, in 1979 Congress explicitly left undisturbed its previous displacement of competition for *inpatient* hospital services in the 1974 Act.

The first paragraph of section 300k-2(b) of the 1979 Act is Congress' finding on the effect of competition:

> "(1) The Congress finds that the effect of competition on decisions of providers respecting the supply of health services and facilities is diminished. The primary source of the lessening of such effect is the prevailing methods of paying for health services by public and private health insurers, *particularly for inpatient health services* and other institutional health services. *As a result, there is*

duplication and excess supply of certain health services and facilities, particularly in the case of inpatient health services." 42 U.S.C. § 300k-2(b)(1) (emphasis added).

The second and third paragraphs of section 300k-2(b) of the 1979 Act deliberately distinguish between services where competition should *not* be encouraged, specifically including *inpatient* services, and services where competition should be encouraged:

> "(2) For health services, *such as inpatient health services* and other institutional health services, *for which competition does not or will not appropriately allocate supply* consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies *should* in the exercise of their functions under this subchapter *take actions* (where appropriate to advance the purposes of quality assurance, cost effectiveness, and access and the other purposes of this subchapter) *to allocate the supply of such services."*
>
> "(3) For the health services *for which competition appropriately allocates supply* consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the performance of their functions under this subchapter give priority (where appropriate to advance the purposes of quality assurance, cost effectiveness, and access) to actions which would strengthen the effect of competition on the supply of such services."

42 U.S.C. § 300k-2(b)(2), (3) (emphasis added).

The *amicus* brief of the Solicitor General, in asserting that Congress "did not foreclose competition in [the] institutional setting *if* competition is in fact found to be working" (S.G. Br. at 20) (emphasis added), fails to recognize that Congress

specifically found in 1974, and again in 1979 (although the 1979 finding is not relevant to this case), that free competition in inpatient services was *not* working. While it is true that in 1979 Congress recognized that the day might come when inpatient services could be allocated by competition, it was abundantly clear in 1974 and 1979 that competition among inpatient facilities at each of those times was counter to the public interest.[13]

The *amicus* brief also overlooks the very specific instructions of Congress in 1979 that, in the case of inpatient services, planning bodies "should" displace competition and allocate supply themselves. 42 U.S.C. § 300k-2(b)(2). As stated in the Conference Reports accompanying the 1979 Act, the findings of Congress "make it clear that for health services, such as inpatient health services and other institutional health services for which competition does not or will not appropriately allocate supply consistent with the plans of the health planning agencies, *the agencies should perform their functions to allocate the supply of those services* . . . ." S. Rep. No. 96-309, 96th Cong., 1st Sess. 58 (1979); H. R. Rep. No. 96-420, 96th Cong., 1st Sess. 58, *reprinted in* [1979] U.S. Code Cong. & Ad. News 1422, 1425 (emphasis added).[14]

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13 Similarly, all the material cited by petitioner (Pet. Br. at 11-12 n.10, 38) for the proposition that commentators and legislators *recently* "have begun to advocate increased reliance on market forces," postdates the 1974 Act and either is limited to prepaid or outpatient programs or is premised on total restructuring of the present system of reimbursement to attempt to create classic marketplace forces. Most of these proposals can be traced to the "Chicago School" of economics, whose laissez-faire theory obviously was not the philosophical underpinning of the 1974 Health Planning Act's approach to inpatient hospital facilities. Since petitioner's hospital does not operate on a prepaid basis, and since Congress developed health planning in 1974 on the premise that the current means of third party reimbursement would continue to exist, the proposals cited by petitioner are of only theoretical interest for present purposes.

14 Indeed, as if to underscore the rejection of competition for inpatient hospital services, the 1979 Act stressed the "identification and discontinuance of duplicative or unneeded services and facilities," 42 U.S.C. § 300k-2(a)(12), and included a section authorizing federal grants for

Similarly, the Solicitor General's assertion that "[t]here is no indication that the later Congress believed that its predecessor had rejected competition and the antitrust laws in the health care field," is incorrect. (S.G. Br. at 17 n.14). Both the language of section 300k-2(b) itself and the Conference Reports in 1979 belie such a contention. Moreover, the remarks made on the floor of Congress by Representatives Gramm and Waxman are exactly to the contrary. *See* pp. 18-19 *supra.*

Furthermore, in the 1978 debates concerning amendment of the Health Planning Act of 1974,[15] Representative Paul Rogers, Chairman of the Subcommittee on Health and the Environment, both then *and in 1974,*[16] described the congressional intent of 1974 to override the antitrust laws where there is implementation by private entities. Although petitioner and the Solicitor General characterize Mr. Rogers' remarks disparagingly, it should be noted that Mr. Rogers for many years was "Mr. Health" in the Congress. He was the principal author of the 1974 Act. As Committee chairman, principal author and floor manager, he had more familiarity with this law than any other individual.[17] Mr. Rogers' statements merit particular attention:

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the purpose of paying hospitals *to close down.* 42 U.S.C. §§ 300t-11-300t-14. These provisions establish a mechanism whereby HSAs are instructed to identify excess facilities in their area and assist in converting them to other uses or discontinuing them, using the funding made available as an incentive to ease the impact of such closings.

15 In 1978 a health planning bill was passed by the Senate but not acted on by the House in time to be voted on before Congress adjourned. *See* S. Rep. No. 96-96, 96th Cong., 1st Sess. 48, *reprinted in* [1979] U.S. CODE CONG. & AD. NEWS 1306, 1353.

16 Representative Waxman succeeded Representative Rogers as chairman in 1979.

17 The cases cited by petitioner and the Solicitor General regarding post-enactment remarks by Congress bear no relationship to this situation. (Pet. Br. at 21-22 n.17; S.G. Br. at 18-19 n.15). *See* United States v. United Mine Workers, 330 U.S. 258, 282 (1947) (remarks were made eleven years after passage of the relevant statute by certain senators, some of whom had not been members of the Senate at the time of passage, and none of whom had been on the committee which

"Although Public Law 93-641 [the Health Planning Act of 1974] contains no specific exemption from the antitrust laws, an analysis of the activities required of HSA's and providers indicates that Congress sanctioned actions which might otherwise be in violation of our antitrust laws. *The intent of Congress was that HSA's and providers who voluntarily work with them in carrying out the HSA's statutory mandate should not be subject to the antitrust laws. If they were, Public Law 93-641 simply could not be implemented.*" 124 Cong. Rec. H11,962-11,963 (daily ed. Oct. 10, 1978) (emphasis added).[18]

Thus, Congress left no doubt in 1979 that planning, not competition or antitrust, should continue to allocate the supply

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reported the bill); United States v. Philadelphia National Bank, 374 U.S. 321, 343-49 (1963) (post-enactment statements conflicted with statements made at the time of passage of the relevant statute); Regional Rail Reorganization Cases, 419 U.S. 102, 132 (1974) (same). Neither petitioner nor the Solicitor General has cited *any* legislative history from 1974 which conflicts with Mr. Rogers' statements.

Moreover, contrary to petitioner's assertion (Pet. Br. at 21-22 n.17), this Court has recognized that post-enactment statements may properly be consulted where they shed light on Congress' intent. *See* Andrus v. Shell Oil Co., 446 U.S. 657, 666 n.8, 668-71 (1980); Nashville Milk Co. v. Carnation Co., 355 U.S. 373, 382 (1958) (post-enactment remarks of Representative Patman, "epitomizing the conclusions to be drawn from the legislative history" of the Robinson-Patman Act). As the principal architect of health planning legislation, and its closest congressional student, Mr. Rogers was uniquely qualified to evaluate the ruinous impact antitrust liability would have had on the cooperative system between providers and HSAs that Congress had erected. Mr. Rogers is certainly more authoritative than the law review commentary cited by petitioner. (Pet. Br. at 38).

18 Petitioner and the Solicitor General also have argued that Representative Rogers' remarks are inapposite because he was not referring to the specific factual situation presented in this case. When the remarks are read in full context, however, it becomes clear that Representative Rogers referred to hospitals only as an "example" of provider cooperation and referred to the interaction of the Health Planning Act of 1974 and certificate of need legislation as only one indication of Congress' intent that there be an implied repeal of antitrust. It is noteworthy that the 1974 Act clearly defined "provider" to include insurers such as Blue Cross. 42 U.S.C. § 300*l*-1(b)(3)(C)(ii)(III).

of inpatient hospital services, and that this had been the intent also in 1974. In 1974, the chief concern of Congress had been elimination of overbedding through planning—and there was not a hint of competition or antitrust intruding upon the planning process. In 1979, competition became a consideration for some programs, but even then competition did not become part of the statutory design for inpatient services.

The Solicitor General here is substituting what he now believes Congress *should* have done in 1974, not what Congress actually did. Also, it may be noted, nowhere in the 1974 congressional proceedings was this "pro-competition" position advanced by the Department of Justice.

The legislative record amply demonstrates that congressional intent in the Health Planning Act of 1974 did not embrace competition for inpatient facilities such as those of the petitioner hospital.

II. Congress Intended to Implement the Health Planning Act of 1974 Through Cooperation by Private Entities

A. Cooperation by Private Entities in Implementing the Health Systems Plan Was Essential to the Statutory Scheme

Implementation of health planning by private entities such as hospitals and insurers has long been important to federal health planning. The 1966 Act opened with a declaration that attainment of the highest possible level of health care "depends on an *effective partnership,* involving . . . official and *voluntary* efforts, and *participation of individuals and organizations.*" Pub. L. No. 89-749, § 2, 80 Stat. 1180, § 2 (emphasis added).[19] This "partnership" took various forms. For example,

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19 The 1966 Act also stressed that the planning which each state was expected to undertake individually had to "provide for encouraging cooperative efforts among governmental or nongovernmental agencies, organizations, and groups concerned with health agencies, facilities, or manpower. . . . " Pub. L. No. 89-749, 80 Stat. 1180, at 1181 § 3(a)(2)(D), codified at 42 U.S.C. § 246(a)(2)(D).

among the measures instituted by the areawide comprehensive health planning agencies created under the 1966 Act were voluntary moratoriums on new hospital construction, which were agreed to by providers in a number of cities "[f]aced with rapidly growing supplies of hospital beds." S. Rep. No. 93-1285, 93d Cong., 2d Sess. 11, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7852. One of these was Kansas City itself, where a cooperative moratorium had served to prevent the construction of unneeded hospital beds prior to passage of the Health Planning Act of 1974. *Id.* Significantly, this program was applauded by the Senate in 1974. *Id.* Had Congress intended to subject to the antitrust laws the actions of providers who carry out an HSA determination, it would hardly have singled out for commendation a "cooperative moratorium" that, in antitrust terms, would be regarded as an anticompetitive cartel.

When it came to the Health Planning Act of 1974, Congress was even more explicit. First, it established the HSAs and required participation by both consumers (in the majority) and providers, including insurers such as Blue Cross. Second, it charged each HSA with formulating a Health Systems Plan to guide all health care entities in its region.

But that was not all. Congress demonstrated that it intended more than just promulgation of a Health Systems Plan by the HSA, directing that "[t]he agency shall seek, to the extent practicable, *to implement* its [Health Systems Plan] . . . *with the assistance of individuals and public and private entities* in its health service area." 42 U.S.C. § 300*l*-2(c)(1) (emphasis added).[20] As stated in the Senate Report: "A health planning agency is directed to seek to implement its long-range goal plan and short-term priorities plan with the assistance of individuals and public and private entities in its health area." S. Rep. No.

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20 While petitioner emphasizes the words "to the extent practicable" (Pet. Br. at 20), this merely signifies that since implementation by private entities is based on cooperation, not compulsion, there may be limits to the implementation the HSAs are able to expect from them.

93-1285, 93d Cong., 2d Sess. 49, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7888.

As later described by Representative Dr. Tim Lee Carter, one of the authors of the 1974 Act, health planning is a special species of regulation:

> "This is not regulation in the style of an Interstate Commerce Commission or a Food and Drug Administration; *health planning is a cooperative system* which provides an opportunity for all of the actors in the health care scene to participate in the decision making process." 125 Cong. Rec. H6212 (daily ed. July 19, 1979) (emphasis added).

The hub of this cooperation is the HSA. As noted earlier, each HSA has a broad-based governing body composed of consumers of health care *and* "providers," including hospitals and third-party payers such as Blue Cross Plans. 42 U.S.C. § 300*l*-1(b)(3)(C). The active involvement of providers is assured through the Act's requirement that between forty and forty-nine percent of the members of each HSA governing body be providers of health care. *Id.* at § 300*l*-1(b)(3)(C)(ii). Congress mandated that since the provider is "one of the most important participants" in the health care sector, "it is *imperative* that the provider be encouraged to play an active role in developing health policy *at all levels.*" *Id.* at § 300k(a)(5) (emphasis added).

Providers, then, in the first instance, participate in formulating the Health Systems Plan ("HSP"). The HSP is meant to serve as a blueprint for future development of all health services in the HSA's area, furnishing a "public statement of the community's goals and objectives." S. Rep. 96-96, 96th Cong., 1st Sess. 37, *reprinted in* [1979] U.S. Code Cong. & Ad. News 1306, 1342. The HSP is "intended to form the foundation upon which the entire health planning process would be built." *Id.* at 63, *reprinted at* 1368. As explained by MAHSA, "The Plan should be used by community leaders as a

decision making tool for the allocation of local public and private health care resources." (J.A. at 43a).

MAHSA recognized that the cost of inpatient services was influenced by the "nature of third party reimbursement programs" and accordingly concluded that its plans for containing inpatient costs should "require that . . . [t]he reimbursement system promote appropriate utilization of hospital services. . . ." (J.A. at 66a-67a).[21] Emphasizing the importance of such implementation, the MAHSA Health Systems Plan included the following appraisal:

> "The Agency realizes that without the assistance, involvement and willing participation of consumers, providers, elected officials and other community leaders, no Health Systems Plan, no matter the quality, will be implemented." (J.A. at 40a).

Consistent with this, Blue Cross' criteria for contracting with hospitals required that "health care institutions and institutional services shall be approved . . . by the . . . area-wide health planning agency." (J.A. at 146a). This policy did no more than incorporate MAHSA's policy. It created no standards and authorized no judgments of Blue Cross' own; rather, Blue Cross embraced the standards and adopted the judgments of the HSA *in toto*. Indeed, what else could Blue Cross have done? Its only alternative was to flout the express objectives of the Health Planning Act of 1974 and undermine MAHSA's Health Systems Plan, rather than "implement" it.

The illogic of petitioner's cause of action is highlighted by comparing the language of the 1974 Act with the allegations of the Complaint. The Act instructs the HSA to prevent "unnecessary duplication," 42 U.S.C. § 300*l*-2(a)(4), and "to implement its HSP. . . with the assistance of individuals and public

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21 Petitioner's assertion that "the only provisions of the MAHSA Plan dealing specifically with third-party payers relate to the development of uniform reporting systems and procedures" is erroneous. (Pet. Br. at 38 n.35).

and private entities." 42 U.S.C. § 300*l*-2(c)(1). The Complaint alleges:

> "Defendants Blue Cross and BCA have combined, contracted and conspired with each other and with co-conspirator MAHSA; with each other and with co-conspirators Gary L. Ihde and Elias E. Zirul, acting in their capacities as an officer and members of the board of MAHSA; and with each other and with co-conspirators Earl E. Horton and Independence Sanitarium and Hospital, acting on behalf of and representing the interests of area hospital competitors of plaintiff, (i) to deny plaintiff hospital Blue Cross Participating Membership thereby foreclosing plaintiff's access to a significant portion of the health care services market, and (ii) to limit, restrict and foreclose plaintiff's entry into the health care services market as a health care provider on an equal basis with competitor area hospitals." (Complaint ¶ 18(e), J.A. at 12a).

Petitioner's claim is that by doing exactly what was intended by the Health Planning Act of 1974—by implementing the MAHSA Health Systems Plan—Blue Cross could violate the antitrust laws. The clear repugnancy between the two statutory schemes is brought into sharp focus by nothing so well as this very claim.

B. The Enactment of State Certificate of Need Legislation Did Not Supplant Implementation Through Cooperation by Private Entities

A second avenue for effectuating the goals of health planning opened up in the late 1960's and early 1970's through state certificate of need programs. These programs continued under and were incorporated into the Health Planning Act of 1974. They were to be administered by a state health planning and development agency ("SHPDA"), which was made responsible for statewide planning under the guidance of the regional HSAs. 42 U.S.C. § 300m-2(a)(4)(B). For the first time, the

1974 Act made state adoption of prescribed certificate of need programs a prerequisite for federal health funding. This eventually encouraged every state, except Louisiana, to adopt such a law.[22] Since certificate of need laws are required to "provide for procedures and penalties" for enforcement in order to meet federal standards, 42 U.S.C. § 300m-2(a)(4)(B), they have proved to be effective in preventing the construction of unneeded hospitals and therefore have attracted considerable attention in recent years. But they did not extinguish the other means of health planning for inpatient hospital facilities, including cooperative implementation by providers such as Blue Cross. *See* pp. 24-28 *supra*.

Petitioner, however, asserts that under the Health Planning Act of 1974, "an HSA's *sole* function with respect to new hospital construction is to advise state health agencies" with regard to effectuating state certificate of need programs. (Pet. Br. at 4) (emphasis added); (*cf.* S.G. Br. at 13). This is not so. Petitioner's argument is based on the contention that because, between June 30, 1976 and the later passage of Missouri's certificate of need law (effective October 1, 1980), Missouri had no state certificate of need legislation, the Health Planning Act and MAHSA were serving no regulatory function in Missouri at that time at all. Missouri's delay, however, did not detract from the applicability of the Health Planning Act of 1974, from cooperative implementation by providers, or from the duties of the HSAs operating in that state, including reduction of "documented inefficiencies" and implementation of their Health Systems Plans. 42 U.S.C. § 300*l*-2(a). It did not mean that there was no "federal regulatory scheme" (Pet. Br. at 25), but only that there was no *state* involvement in the scheme. Petitioner cannot escape the provisions of the 1974 Act merely because the State of Missouri hesitated in enacting its own legislation.[23] If the petitioner were correct, MAHSA's

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22 *See* note 6 *supra*.

23 The Court of Appeals pointedly disposed of this argument, saying that petitioner's "emphasis upon the fact that Missouri was not a participating state . . . misses the focus of the doctrine of implied

formulation of a Health Systems Plan for Missouri would have been nothing but an idle exercise and the references to "implementation" in the 1974 Act would have been meaningless.

The Health Planning Act of 1974 provides *two* tracks for implementation. One section of the Act calls for private, cooperative implementation, instructing the HSA "to implement" its Health Systems Plan with the assistance of private entities. 42 U.S.C. § 300*l*-2(c)(1). *Another* section of the Act instructs the HSA "[t]o assist" SHPDAs in carrying out their functions under state certificate of need programs. 42 U.S.C. § 300*l*-2(F).[24]

There are two different sections. There are two different ways to achieve the objective of Congress—to stop duplication of inpatient facilities.

In fact, the certificate of need concept was not immediately embraced by all the states. In 1974 only 24 states had adopted certificate of need laws. 120 Cong. Rec. 37213 (1974). It was not until *after* passage of the 1974 Act that certificate of need legislation was required for federal funding, and even then, the remaining states were allowed the time necessary to put these laws into effect. Thus, among other things, implementation of Health Systems Plans was necessary, apart from certificate of need legislation, during the anticipated hiatus in many states. Although certificate of need programs assumed increasing significance, cooperative implementation remained an important feature of the Act.[25]

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immunity. The doctrine should not be confused with the state action exemption to the antitrust laws as articulated in Parker v. Brown, 317 U.S. 341 (1943)." (J.A. at 206a; *see also* J.A. at 207a).

24 The dictionary defines "implement" as "to carry out" and "to give practical effect to and ensure of actual fulfillment by concrete measures." It defines "assist" as "to give support or aid" and to "help." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 132, 1134 (1971).

25 In a related argument, petitioner erroneously asserts that because Congress at one time considered a specific provision involving insurance reimbursement and decided to enact a different, stronger provi-

In sum, the Health Planning Act of 1974 was the product of a congressional resolve to control inflation in health care by preventing unnecessary duplication of hospital facilities through comprehensive planning by federally designated and funded regional agencies. Congress placed reliance for effectuation of this planning, in part, on implementation by private parties. What emerges is that in 1974 Congress intended (1) to halt unnecessary duplication of inpatient hospital facilities; (2) to substitute planning for competition as the means to reach that end; (3) to encourage private implementation of planning, in addition to relying on state certificate of need mechanisms; and, necessarily, (4) to preclude antitrust from interfering with this scheme.

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sion instead, it could not have intended to immunize this action taken by a private insurer. (Pet. Br. at 21, 37 n.33).

In 1974, when state certificate of need approval was being made a prerequisite to federal funding (*see* pp. 28-29 *supra*), there was a proposal in Congress to provide an alternative. States would have been permitted *either* to establish certificate of need mechanisms *or* to adopt laws forbidding third-party insurers from reimbursing unneeded services. Third-party insurers had cooperated with local planning agencies in formulating their reimbursement policies for years, as Congress was aware. *See* National Health Planning and Development Act, 1974: Hearings on S. 2994, S. 3139, S. 2796 and Related Bills Before the Subcommittee on Health of the Committee on Labor and Public Welfare, 93d Cong., 2d Sess. 542, 545, 586, 588, Part 2 (1974) (statement of D. Eugene Sibery).

Since not all patients are subscribers to third-party insurance plans, however, this would not have been as airtight a deterrent to duplication of facilities as certificate of need requirements. As ultimately passed, the 1974 Act only gives the states the option of enacting certificate of need laws or foregoing federal assistance.

Petitioner's footnote contention that BCA "had attempted to convince the Congress that it should legitimize the very conduct under attack here," at the 1974 hearings is a considerable distortion. (Pet. Br. at 33 n.29). A witness for BCA merely testified that the policy of many Blue Cross Plans not to contract with hospitals which violate planning guidelines could serve as a model for federal financing. Congress in no way rejected this practice, but opted in the 1974 Act for an *even tighter* prerequisite for federal funding in the form of certificate of need laws.

III. Repeal of the Antitrust Laws Should Be Implied in the Circumstances of this Case Because of the Irreconcilable Conflict Between Anticompetitive Inpatient Hospital Planning and Competition

The fulcrum of petitioner's case is the principle that "the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress." *Northern Pacific Railway Co.* v. *United States,* 356 U.S. 1, 4 (1958). (Pet. Br. at 15). In fact, Congress in 1974 found exactly the opposite: that the unrestrained interaction of competitive forces for inpatient hospital services does *not* serve the public interest and should *not* be encouraged because "the health care industry does not respond to classic marketplace forces." S. Rep. No. 93-1285, 93d Cong., 2d Sess. 39, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7878. The conclusion of Congress in 1974 was that the last thing this country needed was "competition" in the form of building more duplicative hospital beds. *See* pp. 10-17 *supra.*

The decisions of this Court establish that where there is repugnancy between the antitrust laws and other, later enacted statutory schemes—where repeal of antitrust is necessary to make the other statutory scheme work—repeal of the antitrust laws will be implied. *United States* v. *National Association of Securities Dealers, Inc.,* 422 U.S. 694 (1975); *Gordon* v. *New York Stock Exchange, Inc.,* 422 U.S. 659 (1975).

In *National Association of Securities Dealers,* the Government unsuccessfully challenged as violations of the Sherman Act practices of mutual funds, underwriters, broker-dealers, and the National Association of Securities Dealers ("NASD") designed to prevent development of a secondary market in mutual fund shares. NASD was registered as an association of securities dealers pursuant to the Maloney Act of 1938, which provides for "a system of cooperative self-regulation through voluntary associations. . . ." 422 U.S. at 701 n.6. Under the Investment Company Act of 1940, NASD was given certain

supervisory powers over mutual funds, and the legislative history of the Act demonstrated that Congress disapproved of the development of a mutual fund secondary market. Consistent with that finding, NASD and the other defendants entered into various agreements between parties at different levels, and among the dealers at the same level, which effectively prohibited the development of a secondary market. The Government claimed that these amounted to both vertical and horizontal conspiracies in restraint of trade, illegal under the antitrust laws.

Addressing the vertical conspiracy charges first, this Court rejected defendants' claim that there was an express exemption for their conduct under Section 22(d) of the Investment Company Act,[26] but went on to find an implied repeal of antitrust on the basis of Section 22(f). 422 U.S. at 720-22. That section permitted mutual funds to restrict the transferability of their shares so long as such restrictions conformed to disclosures in the funds' registration statements and did not contravene any rules which the Securities and Exchange Commission might prescribe. The transfer restrictions at issue in *NASD* conformed to registration statement disclosures. The SEC had not prescribed any rules on the subject at all.

The Government argued that there was no repugnancy between Section 22(f) and the antitrust laws because the SEC had never exercised its power to regulate. This Court found that such exercise was unnecessary:

> "Our examination of the language and history of § 22(f) persuades us . . . that the agreements challenged . . . are among the kinds of restrictions Congress contemplated when it enacted that section. And this conclusion necessarily leads to a determination that they are immune from liability under the Sherman Act, for we see

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26 Section 22(d) provides that "no dealer shall sell [mutual-fund shares] to any person except a dealer, a principal underwriter, or the issuer, except at a current public offering price described in the prospectus." 15 U.S.C. § 80a-22(d).

> no way to reconcile the Commission's power to authorize these restrictions with the competing mandate of the antitrust laws." 422 U.S. at 721-22.

The Court observed that normally the challenged restrictions would amount to concerted refusals to deal and resale price maintenance agreements in violation of the Sherman Act, but held that:

> "In this instance the antitrust laws must give way if the regulatory scheme established by the Investment Company Act is to work." *Id.* at 729-30.

Turning to the horizontal conspiracy charges, the Court explained that the private agreement among NASD and its member broker-dealers not to participate in a secondary market was "*neither required* by § 22(d) *nor authorized* under § 22(f)." 422 U.S. at 730 (emphasis added). As the Government alleged, it was "designed to encourage the suppression of intrafund secondary market activities." *Id.* at 733. But the Court pointed out that this was "precisely the restriction that the SEC consistently has approved pursuant to § 22(f) for nearly 35 years. This close relationship is fatal to the Government's complaint. . . ." *Id.* The Court concluded:

> "Here implied repeal of the antitrust laws is 'necessary to make the [regulatory scheme] work.' *Silver* v. *New York Stock Exchange,* 373 U.S. at 357. In generally similar situations, we have implied immunity in particular and discrete instances to assure that the federal agency entrusted with regulation in the public interest could carry out that responsibility free from the disruption of conflicting judgments that might be voiced by courts exercising jurisdiction under the antitrust laws. See *Hughes Tool Co.* v. *Trans World Airlines,* 409 U.S. 363 (1973); *Pan American World Airways, Inc.* v. *United States,* 371 U.S. 296 (1963). In this instance, maintenance of an antitrust action for activities so directly related to the SEC's responsibilities poses a substantial danger that appellees

would be subjected to duplicative and inconsistent standards. This is hardly a result that Congress would have mandated." *Id.* at 734-35.

Likewise, in the present case, the conduct of Blue Cross, precisely implementing the determination of MAHSA against new hospital construction, is "directly related" to the responsibility for "preventing unnecessary duplication of health resources" which is at the heart of the Health Planning Act of 1974. Similarly, exposure of Blue Cross to liability for its cooperation with the MAHSA determination also is "hardly a result that Congress would have mandated."

It is no answer to say that Blue Cross was not "compelled" to honor MAHSA's determination. (Pet. Br. at 26; S.G. Br. at 12-13). The Health Planning Act of 1974 is built on "implementation" by entities such as Blue Cross. To require compulsion as a prerequisite to antitrust immunity here would be to destroy the chances for any regulatory scheme based on cooperative implementation ever to succeed.[27] In *NASD* the

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27 The concept of compulsion developed in cases arising under the "state action" doctrine, where the intent of one sovereign (the state) to regulate had to be measured against the intent of a second sovereign (the United States) to apply antitrust. *See* Goldfarb v. Virginia State Bar, 421 U.S. 773, 790-91 (1975). The state action doctrine is not truly an "exemption" at all, but a shorthand expression of the fact that Congress never intended antitrust to apply to certain types of state regulation. City of Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 393 n.8 (1978).

For implied repeal, where the same sovereign has adopted both the regulatory scheme and the antitrust laws, a congressional intent to repeal antitrust can be implied irrespective of compulsion—as it was in *NASD* and *Gordon*. Indeed, there is some question whether compulsion remains a requirement for applying state action immunity after this Court's decision in California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980), which established a test of clear articulation and affirmative expression of a restraint as state policy, coupled with active supervision. In any event, the test for reconciling the intentions of two sovereigns is not the test applicable for judging whether one Congress intended to limit the legislation of an earlier Congress. Petitioner's reliance on state action cases is incorrect. (Pet. Br. at 28).

alleged vertical conspiracy was not required by the SEC. And the alleged horizontal conspiracy was neither authorized nor required. As this Court pointed out, agreement among the dealers and NASD was "ancillary" to the vertical restraints and subject to the regulatory scheme, and therefore immune from antitrust. 422 U.S. at 734. Like the SEC, MAHSA was in a position to change the action of Blue Cross, by changing MAHSA's determination and finding a need for petitioner to build its hospital. This would have led to approval, as a matter of course, by Blue Cross.

Gordon v. *New York Stock Exchange, Inc.*, 422 U.S. 659, 689 (1975), also bears on this point. In *Gordon*, the New York Stock Exchange and two of its member-brokers were charged with price-fixing for establishing and adhering to fixed commission rates as authorized, but not required, by the Securities and Exchange Commission. The United States, as *amicus*, argued there that if the Exchange had been *ordered* by the SEC to charge fixed commissions, antitrust immunity should attach, but since the SEC had only studied and approved the use of fixed commissions, which the Exchange had adopted by choice, immunity should be denied. This argument was rejected by this Court:

> "We believe that this degree of scrutiny and approval by the SEC is not significantly different for our purposes here than an affirmative order to the exchanges to follow fixed rates. . . . We conclude that immunity should not rest on the existence of a formal order by the SEC, but that the actions taken by the SEC pursuant to § 19(b)(9) . . . are to be viewed as having an effect equivalent to that of a formal order." 422 U.S. at 689 n.13.

Petitioner similarly asserts that MAHSA, like the SEC, "never requested Blue Cross to undertake its action." (Pet. Br. at 37-38). But such a request would have been redundant. The MAHSA Plan, in 1977, already called on reimbursers to "promote appropriate utilization" of inpatient services. (*See* p. 4 *supra*). And Blue Cross, which was represented on the MAHSA board, previously had adopted a requirement in 1976

that new hospitals "shall be approved . . . by the designated planning agency." (*See* p. 5 *supra*). Nothing in the Health Planning Act of 1974 required any more formal arrangement than this—and petitioner considered it sufficiently concrete to label it a conspiracy. (*See* p. 28 *supra*).

The root of the matter is that the 1974 Act and the antitrust laws are inimical to one another and establish conflicting standards. In *Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659 (1975), this Court held:

> "We agree . . . that to deny antitrust immunity with respect to commission rates would be to subject the exchanges and their members to conflicting standards. It is clear . . . that the commission rate practices of the exchanges have been subjected to the scrutiny and approval of the SEC. If antitrust courts were to impose different standards or requirements, the exchanges might find themselves unable to proceed without violation of the mandate of the courts or of the SEC. Such different standards are likely to result because the sole aim of antitrust legislation is to protect competition, whereas the SEC must consider, in addition, the economic health of the investors, the exchanges, and the securities industry. Given the expertise of the SEC, the confidence the Congress has placed in the agency, and the active roles the SEC and the Congress have taken, *permitting courts throughout the country to conduct their own antitrust proceedings would conflict with the regulatory scheme authorized by Congress rather than supplement that scheme.*" 422 U.S. at 689-90 (footnotes omitted; emphasis added).

Here, Blue Cross would face, in the words of *Gordon* and *National Association of Securities Dealers,* the "conflicting" and "inconsistent" standards of planning and antitrust if the antitrust laws were to apply.

There are two important national policies in direct conflict here: "the policy unequivocally laid down by the [Sherman]

Act is competition," *Northern Pacific Railway Co.* v. *United States,* 356 U.S. 1, 4 (1958); the policy unequivocally laid down by the Health Planning Act of 1974 is the anticompetitive aim of "preventing unnecessary duplication" of hospital beds through planning. 42 U.S.C. § 300*l*-2(a)(4).[28] Economic planning is the antithesis of competition; the Health Planning Act of 1974 is the antithesis of the Sherman Act in the circumstances of this case. The planning mandated for inpatient hospital facilities is so antagonistic to the antitrust laws that the two are plainly "repugnant" to one another.

Furthermore, congressional reliance in the Health Planning Act of 1974 on implementation by insurers and other providers would be frustrated by the threat of antitrust liability. (*See* pp. 24-28 *supra.*) The regulatory scheme could not "work." Blue Cross was represented on the HSA which developed the Health Systems Plan, as provided in the Act. It cooperated in implementing the HSP, as provided in the Act. It confounds logic to imagine that Congress, having summoned providers to cooperate in implementation, intended to leave them exposed to antitrust liability for following the Health Systems Plan to the letter. The statutory scheme would have been a legislative absurdity if the very activity it was designed to encourage could become the basis for an antitrust claim.

Petitioner and the Solicitor General cite various cases for the proposition that even where there is formal agency approval, there can be no implied repeal in the absence of an express exemption from the antitrust laws. (Pet. Br. at 29; S.G. Br. at 21). But in each of these cases the Court found that the regulatory scheme was reconcilable with antitrust because Congress, in fact, intended the antitrust laws to apply. *United States* v. *Radio Corporation of America,* 358 U.S. 334, 339-46 (1959); *California* v. *Federal Power Commission,* 369 U.S.

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28 In contrast, it would be illegal in the usual commercial context for a group of companies to get together to limit production. *See, e.g.,* Westinghouse Elec. Corp. v. Gulf Oil Corp., 588 F.2d 221, 226 (7th Cir. 1978).

482, 486 (1962); *United States* v. *Philadelphia National Bank*, 374 U.S. 321, 352 (1963). (Pet. Br. at 23-24; S.G. Br. at 21).

Moreover, all of these cases involved traditional, adversarial regulatory schemes bearing little resemblance to health planning. The Communications Act, 47 U.S.C. § 309, the Interstate Commerce Act, 49 U.S.C. § 10706, the Federal Aviation Act, 49 U.S.C. § 1384, and similar federal regulatory provisions, are all grounded in the theory that a limited competitive market—presided over by the watchful eye of the federal regulatory apparatus—will best promote the public interest.

The Health Planning Act has a policy basis quite distinct from these traditional regulatory provisions. As we have shown, the Act is an exercise in cooperation, a joint effort among government and private entities. (*See* pp. 24-28 *supra*).

Petitioner's further statements that Blue Cross really was engaged in unsupervised activity, acting as a "private government" or "extra-judicial tribunal," with "no public oversight of any kind," are incorrect and misleading. (Pet. Br. at 27, 31; *see also* S.G. Br. at 22). Not only did the Health Planning Act of 1974 call for "implementation" by providers such as Blue Cross (*see* p. 25 *supra*), but the fact of the matter is that Blue Cross established no community need standards of its own. Blue Cross simply followed the precise determinations of MAHSA, requiring only that "institutional services shall be approved . . . by the . . . area-wide health planning agency." (J.A. at 146a). This situation is worlds apart from *Fashion Originators Guild* v. *FTC*, 312 U.S. 457, 465 (1941), where an industry group sat as legislature, judge and jury.[29]

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29 In the cases cited by petitioner and the Solicitor General (Pet. Br. at 27; S.G. Br. at 22-23), the private entities involved were making judgments beyond the contemplation of any regulatory scheme and not in furtherance of the goals of any regulatory scheme. *See* Silver v. New York Stock Exchange, 373 U.S. 341, 361 (1963) (challenged conduct did not serve any purpose reflected in the SEC Act); Otter Tail Power Co. v. United States, 410 U.S. 366, 373-74 (1973) (conduct did not further the goals of the Federal Power Act); United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 227 (1940) (conduct was not within the contemplation of the National Industrial Recovery Act); Fashion

Faithful to its federal mandate, MAHSA, which was no officious intermeddler, made a reasoned determination, following an investigation and public hearings, that additional hospital beds in the Kansas City area were unwarranted. (J.A. at 102a). Blue Cross did nothing more than carry out MAHSA's determination, as provided under the cooperative system established by the Act. *See* p. 25 *supra*. Not only were MAHSA's investigation and Health Systems Plan required by the Health Planning Act of 1974, but every step of MAHSA's procedure was carried out pursuant to the detailed requirements of the Act.[30] As stated by the Solicitor General, "HSA decisionmaking is public and open, and carefully supervised." (S.G. Br. at 16 n.11). The "real decision-maker" (Pet. Br. at 30) here was MAHSA, not Blue Cross.

Moreover, MAHSA's determination was subject to review. Although petitioner complains that there was no mechanism for review (Pet. Br. at 33), it could have sought reconsideration of MAHSA's determination of hospital bed oversupply at the time the HSP was formulated. *See* 42 U.S.C. § 300*l*-2(b)(2). It could have sought reconsideration after the Plan was issued. In fact, petitioner never approached MAHSA at all. If petitioner were dissatisfied with MAHSA's response, it could have sought review by the Secretary of HEW of the Plan's adequacy in conjunction with HEW's review of MAHSA's performance, 42 U.S.C. § 300n-4(c)(1), or the renewal of MAHSA's grant. 42 U.S.C. § 300n-4(a). Petitioner did none of those.

Petitioner's additional assertion that, under this Court's decisions, "pervasive regulatory powers" must exist as a precondition to finding implied repeal, is incorrect. (Pet. Br. at 25, 38-41). In *Gordon* v. *New York Stock Exchange, Inc.*, 422

Originators Guild v. FTC, 312 U.S. 457, 465 (1941) (conduct not within the contemplation of, or in furtherance of the goals of any federal regulatory scheme); Associated Press v. United States, 326 U.S. 1, 12-13 (1945) (same); American Medical Ass'n v. United States, 317 U.S. 519, 535-36 (1943) (same).

30 *See* note 10 *supra*. Petitioner does not claim that MAHSA failed to perform any of these obligations.

U.S. 659, 688-89 (1975), this Court stated that a pervasive regulatory scheme is *not* an essential ingredient of the implied repeal doctrine:

> "The United States appears to suggest that only if there is a pervasive regulatory scheme, as in the public utility area, can it be concluded that the regulatory scheme ousts the antitrust laws. . . . It is true that in some prior cases we have been concerned with the question of the pervasiveness of the regulatory scheme as a factor in determining whether there is an implied repeal of the antitrust laws. . . . In the present case, however, respondents do not claim that repeal should be implied because of a pervasive regulatory scheme, but because of the specific provision of § 19(b)(9) and the regulatory action thereunder. . . . Hence, whether the Exchange Act amounts to pervasive legislation ousting the antitrust acts is not a question before us." (Citations omitted).

In any event, this Court need not reach the issue on the facts of this case. There is a pervasive regulatory scheme, since, as pointed out, *supra,* p. 27, the decision-maker here was MAHSA, and Congress intended that MAHSA's Health Systems Plan would embrace all activities with respect to new health services, such as those in issue.

Contrary to the suggestions of petitioner, respondents are not seeking a "blanket exemption." It is revealing that petitioner addresses most of its attention to the district court opinion below, which it claims conferred a "blanket exemption," and devotes far less attention to the Court of Appeals, which drafted its own analysis and never mentioned a blanket exemption. (*Compare* Pet. Br. at 6-7, *with* Pet. Br. at 8).[31] Petitioner claims that the decision below "would provide an umbrella of protection for many types of anticompetitive

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31 The *amicus* Federation of American Hospitals acknowledges that "[t]he Eighth Circuit did not . . . find that the Act created a 'blanket exemption' . . ." (F.A.H. Br. at 5).

activities, so long as they could be said to be in some way consistent with the goals of the Planning Act." (Pet. Br. at 13). So, too, the Solicitor General implies that respondents claimed and were granted antitrust immunity here "simply because Blue Cross may have believed that its alleged exclusionary practices were in furtherance of a general regulatory purpose such as avoiding unnecessary expenditures or duplication of services." (S.G. Br. at 21). This is erroneous—the Court of Appeals adhered to this Court's decisions in *NASD* and *Gordon,* citing and quoting them. (*See* J.A. at 206a, 209a).

The "issue" of blanket exemption is, however, a red herring. Respondents are not seeking an "umbrella of protection" for every type of conduct which is somehow "consistent" with the Act. On the facts of this case, implied repeal is essential to make the statutory scheme work and to avoid frustrating the purpose of Congress. If private entities cooperating with HSAs to implement the precise words of the Health Systems Plan might be liable under the antitrust laws for such action, there would be no implementation at all.

Congress has chosen to enact forms of regulation aimed at "preventing unnecessary duplication," which are based on cooperation with private entities; that choice should not be frustrated by visiting insurers and other providers with exposure to treble damage antitrust suits. The Solicitor General's comment that there is "no basis for inferring that subjection of Blue Cross' conduct to antitrust scrutiny would frustrate any of the [Act's] goals," is erroneous. (S.G. Br. at 13). It makes no difference that, as the Solicitor General recognizes (S.G. Br. at 11 n.8), petitioner would confront several substantive antitrust law barriers to recovery against Blue Cross, if this case were to be tried on the merits. The threat of litigation provides enough of a chilling effect. Congress did not intend that providers such as non-profit Blue Cross should become embroiled in costly antitrust litigation—the expense of which is ultimately borne by its subscribers—to defend claims of "conspiracy" to restrain trade, where all Blue Cross has done is follow the very Health Systems Plan promulgated by the federally established and funded MAHSA.

IV. The Inclusion of an Exemption for Individual Liability in the Health Planning Act of 1974 Has Nothing To Do With Finding an Implied Repeal of Antitrust Here

In the 1974 proceedings there was not a whisper of a wish in Congress to have competition. As described above, the entire thrust of the Health Planning Act of 1974 was to substitute planning for market forces. "[I]n fact," as stated by the *amicus* Federation of American Hospitals, "the subject of antitrust was not an issue while the [1974] Act was being considered." (F.A.H. Br. at 18).

This is not surprising since at the time the 1974 Act was passed, there were very few cases applying antitrust to the types of conduct contemplated in the Act. Indeed, petitioner itself has pointed to "the substantial immunity from the antitrust laws that the health care sector and third-party reimbursement organizations such as respondent Blue Cross have enjoyed in the past." (Petition for a Writ of Certiorari at 8).[32] In 1974 there was no reason for antitrust liability to be an issue during consideration of the Health Planning Act.

Despite this, petitioner and the *amici* make the argument that implication of an antitrust repeal is barred here by the principle of *"expressio unius"* because the 1974 Act, and the

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32 So, too, petitioner stated, "[u]ntil very recently, health care providers and insurers were largely immune from the federal antitrust laws because of various legal hurdles which effectively shielded their conduct from antitrust scrutiny." (Petition for a Writ of Certiorari at 12).

Then, in 1975, this Court's decision in Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975), reversed the Court of Appeals and applied antitrust to the "learned professions." In 1976, in Hospital Building Co. v. Trustees of Rex Hospital, 425 U.S. 738 (1976), this Court, again reversing the Court of Appeals, applied antitrust to hospitals affecting interstate commerce. And, in 1979, the 5-4 decision in Group Life & Health Insurance Co. v. Royal Drug Co., Inc., 440 U.S. 205 (1979), limited the McCarran-Ferguson antitrust exemption for insurers such as Blue Cross, in contrast to several lower court decisions which preceded it. *See, e.g.*, Nankin Hospital v. Michigan Hospital Service, 361 F. Supp. 1199, 1210-11 (E.D. Mich. 1973); Travelers Insurance Co. v. Blue Cross of Western Pennsylvania, 481 F.2d 80, 82-83 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973).

1979 Act, contain express exemptions from certain types of liability.

Again, only the 1974 Act is relevant. The 1974 Act contained a boilerplate exemption from liability for members and employees of an HSA:

> "Individual Liability.—No individual who, as a member or employee of a health systems agency, shall, by reason of his performance of any duty, function, or activity required of, or authorized to be undertaken by, the agency under this title, be liable for the payment of damages under any law of the United States or any State (or political subdivision thereof) if he has acted within the scope of such duty, function, or activity, has exercised due care, and has acted, with respect to that performance, without malice toward any person affected by it." Pub. L. No. 93-641, § 1512(b)(4), 88 Stat. 2225, 2235.[33]

This is merely an exemption from liability to avoid discouraging individuals from serving on HSAs. Although petitioner labels it "a limited immunity from antitrust (and other) damage actions" (Pet. Br. at 18), no one in Congress in 1974 related it to antitrust liability and the limited express exemption for individuals teaches nothing about the intent of Congress with regard to this case.[34] The cases cited by petitioner,

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33 The 1974 exemption is typical of the numerous federal statutes which, in language akin to the 1974 exemption, exempt government employees from personal liability for acts done within the scope of their employment and in good faith. *See, e.g.*, 2 U.S.C. § 170(c) (librarian and employees of Library of Congress); 15 U.S.C. § 78kkk(c) (directors, officers, and employees of Securities Investor Protection Corporation); 19 U.S.C. § 1513 (customs officers); 40 U.S.C. § 489(a) (governmental employees charged with transfer and disposal of government property); 42 U.S.C. § 300j-6(a) (officers, agents, and employees of the United States charged with public water systems safety).

34 As noted by *amicus*, Federation of American Hospitals, the Senate Committee "did not in any fashion indicate that the Senate *considered* or attempted to exempt members of the health care industry from . . . the antitrust laws." (F.A.H. Br. at 18) (emphasis added). The Solicitor

on the other hand, deal with statutes having express exemptions explicitly addressed to "competition" or "antitrust." (Pet. Br. at 19).[35]

To be sure, in 1979, after *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773 (1975); *Hospital Building Co.* v. *Trustees of Rex Hospital,* 425 U.S. 738 (1976); and *Group Life & Health Insurance Co.* v. *Royal Drug Co., Inc.,* 440 U.S. 205 (1979) had been decided, and at a time when Congress was adding provisions aimed at encouraging competition for prepaid and outpatient services (*see* p. 17 *supra*), Congress added onto the exemption a specific exemption from liability for HSAs themselves when performing functions required or authorized by the 1979 Act. It also modified the provision for individual members and employees. Whether these changes in 1979 were intended to alter the existing implied repeal of antitrust, which Congress had intended in 1974, is not a question which this Court must reach. The only issue here is the scope of the implied repeal of the 1974 Health Planning Act itself. For the same reason, the hearing testimony cited by petitioner regarding the proper scope of immunity—all of which was given *in 1979*—is irrelevant for purposes of applying the 1974 Act to the facts of this case. (*See* Pet. Br. at 19-20). It is worth noting, however, that if the HSA is immune from liability—as provided explicitly under the 1979 Act—for "conspiring" with Blue Cross, it would make no sense to subject Blue Cross to liability for engaging in the same alleged conspiracy. *See Alabama Power Co.* v. *Alabama Electric Cooperative, Inc.,* 394 F.2d 672, 676-77 (5th Cir.), *cert. denied,* 393 U.S. 1000 (1968) ("To avoid frustrating the intent of Congress, it must follow that in cases where the Administrator is immune from

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General's reference to "Congress' *considered decision* to grant only a limited express immunity," is groundless. (S.G. Br. at 9) (emphasis added).

35 Federal Maritime Commission v. Seatrain Lines, Inc., 411 U.S. 726, 732-33 (1973); Carnation Co. v. Pacific Westbound Conference, 383 U.S. 213, 216 (1966); United States v. Borden Co., 308 U.S. 188, 201 (1939); Cain v. Air Cargo, Inc., 599 F.2d 316, 320 (9th Cir. 1979).

suit under the antitrust laws, the borrower is likewise immune"); *Champaign-Urbana News Agency Inc.* v. *J.L. Cummins News Co.*, 632 F.2d 680, 692-93 (7th Cir. 1980).

Moreover, the basic premise of petitioner's argument is erroneous as a matter of law. The inclusion of an express immunity provision in a statute does not preclude a finding of implied immunity. In *United States* v. *National Association of Securities Dealers, Inc.*, 422 U.S. 694, 720-22 (1975), immunity was implied because of § 22(f), despite the inapplicability of the express provision in § 22(d) of the Investment Company Act of 1940. And in *Pan American World Airways, Inc.* v. *United States*, 371 U.S. 296, 305-10 (1963), implied immunity was applied to transactions that could not be immunized under the express antitrust exemption of § 414 of the Federal Aviation Act. Here, where the specific exemption in the 1974 Act was unrelated to antitrust, the principle of *expressio unius* has even less—considerably less—applicability.

CONCLUSION

The Court of Appeals correctly determined that the intent of Congress in the Health Planning Act of 1974—to prevent unnecessary duplication of hospital facilities, to specify health planning and to implement this planning through cooperation with private entities such as Blue Cross—included repeal of the antitrust laws in the specific circumstances of this case. The repugnancy between the Health Planning Act of 1974 and the antitrust laws is underscored by the facts here, where Blue Cross did nothing more than implement the MAHSA Health Systems Plan in its precise terms.

For the reasons described above, we respectfully request that the order of the Court of Appeals be affirmed.

Respectfully submitted,

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APPENDIX

STATUTORY PROVISIONS INCLUDED

Section 1 of the Sherman Act, 15 U.S.C. § 1, provides in pertinent part:

> "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. . . ."

Section 2 of the Sherman Act, 15 U.S.C. § 2, provides in pertinent part:

> "Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony. . . ."

The relevant provisions of the National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300k *et seq.* provide in pertinent part:

Section 300k(a):

> "The Congress makes the following findings:
>
> (1) The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government.
>
> (2) The massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources.

(3) The many and increasing responses to these problems by the public sector (Federal, State, and local) and the private sector have not resulted in a comprehensive, rational approach to the present—

(A) lack of uniformly effective methods of delivering health care;

(B) maldistribution of health care facilities and manpower; and

(C) increasing cost of health care.

(4) Increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care for inpatient hospital care.

(5) Since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns of the provider if it is to achieve meaningful results; and, thus, it is imperative that the provider be encouraged to play an active role in developing health policy at all levels.

(6) Large segments of the public are lacking in basic knowledge regarding proper personal health care and methods for effective use of available health services."

Section 300k(b):

"In recognition of the magnitude of the problems described in subsection (a) of this section and the urgency placed on their solution, it is the purpose of this Act to facilitate the development of recommendations for a national health planning policy, to augment areawide and State planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy."

Section 300*l*-2(c):

"A health systems agency shall implement its HSP and AIP, and in implementing the plans it shall perform at least the following functions:

(1) The agency shall seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area."

Section 300*l*-2(f):

"To assist State health planning and development agencies in carrying out their functions under paragraphs (4) and (5) of section 300m-2(a) of this title each health systems agency shall review and make recommendations to the appropriate State health planning and development agency respecting the need for new institutional health services proposed to be offered or developed in the health service area of such health systems agency."

No. 80-802

ALEXANDER L
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER, *Petitioner,*

v.

BLUE CROSS OF KANSAS CITY AND BLUE CROSS ASSOCIATION, *Respondents.*

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

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TABLE OF CONTENTS

PAGE

I. Congress Did Not Intend To Establish A System of Private Cartel Regulation 3

II. The 1979 Amendments Are Inconsistent With Respondents' Position 9

III. The Notion of Antitrust Immunity Without Effective Public Supervision Finds No Support In Prior Decisions Of This Court 13

TABLE OF AUTHORITIES

CASES:

Bates v. *State Bar of Arizona*, 433 U.S. 350 14

California Retail Liquor Dealers Association v. *Midcal Aluminum, Inc.*, 445 U.S. 97 14

Carter v. *Carter Coal Co.*, 298 U.S. 238 13

Eastern Railroad Presidents Conference v. *Noerr Motor Freight, Inc.*, 365 U.S. 127 14

Fashion Originators Guild v. *Federal Trade Commission*, 312 U.S. 457 14

Gibson v. *Berryhill*, 411 U.S. 564 13

Goldfarb v. *Virginia State Bar*, 421 U.S. 773 14

Gordon v. *New York Stock Exchange, Inc.*, 422 U.S. 659 ..... 15, 17-19

New Motor Vehicle Board of California v. *Orrin W. Fox Co.*, 439 U.S. 96 14

Parker v. *Brown*, 317 U.S. 341 14

Schechter Corp. v. *United States*, 295 U.S. 495 13

Silver v. *New York Stock Exchange*, 373 U.S. 341 2

United States v. *National Association of Securities Dealers, Inc.*, 422 U.S. 694 ..... 15-17, 18-19

STATUTES, REGULATIONS AND LEGISLATIVE MATERIAL:

42 U.S.C. §300k-3 4
42 U.S.C. §300*l*-1 4
42 U.S.C. §300*l*-1(b)(1) 2
42 U.S.C. §300*l*-2(a)(3) 13
42 U.S.C. §300*l*-2(a)(4) 13
42 U.S.C. §300*l*-2(b) 2
42 U.S.C. §300*l*-2(f) 2
42 U.S.C. §300*l*-2(g) 2
42 U.S.C. §300m-*et seq.* 1
42 U.S.C. §300m 4
42 U.S.C. §300m-3 4
42 U.S.C. §300m(b)(1) 6
42 U.S.C. §300m-1(b)(1) 6
42 U.S.C. §300m-1(b)(2) 6
42 U.S.C. §300m-1(b)(6) 6
42 U.S.C. §300m-2(a)(1) 6
42 U.S.C. §300m-2(a)(5) 6
42 U.S.C. §300m-3(e)(Supp. III 1979) 16
42 U.S.C. §300n-2(c) 4
42 U.S.C. §300n-3 4
Health Planning And Resources Development Amendments Of 1979, Act Of October 4, 1979, Pub. L. No. 96-79, 93 Stat. 592 (1979) ..... *passim*
Health Planning And Resources Development Amendments Of 1979, Act Of October 4, 1979, Pub. L. No. 96-79, §113(b), 93 Stat. 606 (1979) 16
National Health Planning And Resources Development Act Of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1974) ..... *passim*

Table of Authorities Continued

PAGE

National Health Planning And Resources Development Act Of 1974, Pub. L. No. 93-641, §1512(b)(5), 88 Stat. 2235 (1974) 7

H.R. Rep. No. 190, 96th Cong., 1st Sess. (1979) 12

H.R. Rep. No. 1382, 93d Cong., 2d Sess. (1974) 4, 5

Health Planning And Resources Development Amendments Of 1979: Hearings Before The Subcommittee On Health And The Environment Of The Committee On Interstate And Foreign Commerce On H.R. 3041 And H.R. 3167, 96th Cong., 1st Sess. (1979) . 10-11

S. Rep. No. 96, 96th Cong., 1st Sess., *reprinted in* [1979] U.S. Code Cong. & Ad. News 1306 ..... 5, 6, 9, 11

S. Rep. No. 1285, 93d Cong., 2d Sess., *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842 .... 3, 4, 5, 7

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On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

REPLY BRIEF FOR THE PETITIONER

The fatal flaw in the decision of the court below is found in a single sentence of its opinion, where the court said (628 F.2d at 1055; J.A. at 207(a)):

> Missouri's lack of state participation did not affect the Act which set up a regulatory scheme which designated MAHSA as a regulatory need review agency.

The fact is that MAHSA had no certificate of need authority. Such powers were given by the Act only to a State Health Planning and Development Agency (under 42 U.S.C. §§300m *et seq.* — *see* Appendix to this Brief at 8a), and Missouri had not designated such an agency during the period here in question.

This confusion between the regulatory powers given by the statute to State Health Planning and Development Agencies and the reporting and recommending functions assigned to Health Systems Agencies (*see* 42 U.S.C.

§300*l*-1(b)(1) and §300*l*-2(b), (f), and (g), set out in the Appendix to this Brief at 1a-4a), permeates the respondents' brief. It has led respondents into a line of argument which can be summarized as follows: Congress in 1974 created a two-track scheme of (1) public regulation, using a complicated bureaucracy of federal, state and private groups and enforced through state certificate of need laws and, at the same time, (2) cartel regulation, using local private planning agencies acting in "cooperation" with other private entities. The former was fully debated and carefully designed to place all regulatory powers with public agencies, leaving to private groups only the role of gathering information and making recommendations, with clear lines of review and appeal to the Secretary of HEW (now HHS) and the courts. The latter was never even discussed, and no effort was made to supply due process or other procedural protections or any avenues of administrative or judicial review.

This creative interpretation of the 1974 Act is essential to respondents' position. Only if Congress mandated a system of regulation through wholly private action can it even be argued that repeal of the antitrust laws is "necessary to make [the Act] work." *Silver* v. *New York Stock Exchange,* 373 U.S. 341, 357. But Congress did not turn to self-help in 1974; instead it established a balanced system of regulation *by the States.* Far from approving purely private regulation, Congress was careful to withhold *any* regulatory power from all but public agencies. In 1979, when it reexamined the 1974 Act, Congress explicitly rejected numerous suggestions to grant private actors the antitrust immunity respondents argue was implicit in the 1974 Act. In sum, neither the legislative history of the 1974 Act or its 1979 amendments nor a sense of the legislative process support the

conclusion that Congress ever intended to repeal the antitrust laws in the health care industry, and to do it wholly by implication.

I. CONGRESS DID NOT INTEND TO ESTABLISH A SYSTEM OF PRIVATE CARTEL REGULATION.

The 1974 Health Planning Act was a substantial venture, pulling together various programs enacted over the years and, together with new ideas, molding those separate and to some extent inconsistent efforts into "a single new program of State and area-wide health planning." S. Rep. No. 1285, 93d Cong., 2d Sess. 2, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7843. Respondents' selective description of the background leading up to the 1974 Act, and their reliance on very limited portions of the Act, do not do justice to what was a complex effort to reach a "delicate but workable balance among the varied interests operating in the health care industry." S. Rep. No. 1285, 93d Cong., 2d Sess. 52, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7891.

Previous efforts at health planning had been "only marginally successful" because of "inadequately specific Congressional mandate[s] . . . , inadequate funding, and inadequate authority to implement recommendations." S. Rep. No. 1285, 93d Cong., 2d Sess. 40, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7879. The 1974 Planning Act was designed to meet these problems through the creation of an elaborate structure of several tiers of public and private entities (including representatives of all affected and competing interests), *and* the establishment of a regulatory system under the authority of the States. These were integral parts of a single whole; respondents' attempt to segregate them into parallel —

but separate — "tracks" mischaracterizes the legislation's structure and purpose.[1]

The planning structure included, at the top, a National Council on Health Planning and Development (42 U.S.C. §300k-3), and Statewide Health Coordinating Councils (42 U.S.C. §300m-3). In between were State Health Planning and Development Agencies (SHPDAs), which had to be agencies of State government with appropriate governmental powers. 42 U.S.C. §300m. At the bottom were Health Systems Agencies (HSAs), whose composition was carefully prescribed to include all relevant interest groups. 42 U.S.C. §300*l*-1. The 1974 Act also called for the establishment of centers for multidisciplinary health planning development and assistance, and for the creation of a national health planning information center. 42 U.S.C. §§300n-2(c), 300n-3.

The HSA was given grass roots responsibilities. As described by the Senate Report, these included "the accumulation of data in order to assess the existing status of the health care delivery system in the area it serves, and . . . developing short and long-term recommendations in order to achieve the rational and equitable distribution of personal health care services throughout its planning area." S. Rep. No. 1285, 93d Cong., 2d Sess. 44-45, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7884.[2] It is clear, though, that Congress did

[1] Throughout their brief, respondents use the term "planning" as though it were synonymous with cartel regulation. But there is no indication that Congress had this understanding. In fact, the term "planning agencies" is generally used in the legislative history to include all the bodies — public and private — involved in the planning process. *See, e.g.*, H.R. Rep. No. 1382, 93d Cong., 2d Sess. 33-34 (1974).

[2] The HSAs were not intended to focus primarily on new hospital construction. Indeed, the HSA may engage in many modes of

not intend that HSAs should have any regulatory power. The 1974 Senate Report explains why:

> Although the keystone to the health planning effort envisioned in the proposed Committee legislation is the areawide health planning agency, certain functions are more appropriately performed at the State level. Specifically, the integration and synthesis of areawide health plans into a Statewide health plan, the establishment of priorities within the State, and the performance of regulatory functions are most appropriately carried out at the State level. *The latter function can appropriately be carried out only by an agency of State government.* [S. Rep. No. 1285, 93d Cong., 2d Sess. 52, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7891; emphasis added.][3]

The "regulatory functions" referred to were intended to provide the sanctions that had been missing from earlier planning legislation. Thus, Congress required that

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"implementing" its Plans with the assistance of other parties which, unlike the situation in the present case, have no antitrust implications. For example, the HSA might, in its Plan, identify a need for a Trauma Center or a special emergency medicine facility in its health service area, and work with an academic medical center in the area to establish such a center. Or it might identify the need for a new category of health care personnel, or increasing numbers of existing categories of health manpower, to achieve the goals set forth in its Plan, and work with a junior college in its area to help establish training programs for such personnel. In short, respondents' contention that the "references to 'implementation' in the 1974 Act would have been meaningless" (R. Br. at 30) if the conduct under attack here is not permitted is quite unfounded.

[3] *See also* H.R. Rep. No. 1382, 93d Cong., 2d Sess. 65 (1974): "[T]he Committee feels that regulatory activities are appropriately vested in units of public government." This conclusion was reiterated in the 1979 Senate Report, S. Rep. No. 96, 96th Cong., 1st Sess. 67, *reprinted in* [1979] U.S. Code Cong. & Ad. News 1306, 1372.

each State, on pain of loss of various federal funds, should create a regulatory program with certain mandatory features:

(1) It must be administered by "an agency . . . of the government of that State" (42 U.S.C. §300m(b)(1));

(2) The State Health Planning and Development Agency (SHPDA) must be the "sole agency for the performance" of the functions required of the SHPDA (42 U.S.C. §300m-1(b)(1));

(3) The SHPDA must have "under State law the authority to carry out such functions" (42 U.S.C. §300m-1(b)(2));

(4) The SHPDA must "(A) conduct its business meetings in public, (B) give adequate notice to the public of such meetings, and (C) make its records and data available, upon request, to the public" (42 U.S.C. §300m-1(b)(6)).

The SHPDA was required to "[c]onduct the health planning activities of the State" (42 U.S.C. §300m-2(a)(1)), including administering the State certificate of need program. Again on the pain of losing various federal funds, each State was required to "provide for review and determination of need" for new institutional health services, a program described by the 1979 Senate Report as the "basic component" of the health planning process. S. Rep. No. 96, 96th Cong., 1st Sess. 5, *reprinted in* [1979] U.S. Code Cong. & Ad. News 1306, 1310. In making those determinations, the SHPDA was required to consider — but not necessarily follow — recommendations made by health systems agencies. 42 U.S.C. §300m-2(a)(5).

Respondents argue that there are really two schemes, one "regulatory" and one "planning" — alter-

native methods of reaching the same result. But this construction is incompatible with the language of Congress and the statute it passed. It would be incongruous at best for the Congress that believed that regulatory functions "can appropriately be carried out only by an agency of state government", and which displayed considerable concern about possible conflicts of interests,[4] to create at the same time a system of collusive and perhaps coercive regulation by HSAs and private entities. And it would be senseless to create a carefully-circumscribed procedure of public regulation while simultaneously encouraging private cartel decision-making with no due process protections, no right of appeal — indeed, no right or even expectation that the public would have any idea what deals had been struck, what agreements

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[4] In 1974, the Senate Report noted concerns about conflicts of interests of providers and concluded that "their influence on the health planning process must be appropriately limited." S. Rep. No. 1285, 93d Cong., 2d Sess. 46, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7886. The Senate Report went on to state that

> [I]t wishes to make clear its concern about potential conflicts of interest resulting from support of the activities of the health planning agency by local hospital associations, medical societies, health insurers, or others with a direct financial interest in the provision of health care services. The Committee has provided an appropriate channel of expression for those interests by requiring that they be represented on the health planning agencies' governing body. By including a provision dealing with funding of the health planning agencies, the Committee wishes to preclude the exercise of undue influence by providers. . . ." [S. Rep. No. 1285, 93d Cong., 2d Sess. 47, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7887.]

Because of these concerns, the 1974 Act prohibited funding of HSAs by providers. National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, §1512(b)(5), 88 Stat. 2235 (1974).

reached, what competitive initiative stifled by persuasion or coercion.[5]

Respondents argue that the 1974 Act "has a policy basis quite distinct from . . . traditional regulatory provisions." R. Br. at 39. If respondents' interpretation of the Act is correct, this would be a considerable understatement. Respondents would have us believe that Congress, with 28 words in a statute over 55 printed pages in length, intended to cast aside over 90 years of jurisprudence and adopt a dramatic new approach to economic regulation.[6] To imagine that Congress would take such a step without one word of debate is fanciful.

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[5] Respondents argue that, even under their interpretation of the Planning Act, petitioner could have sought review of the MAHSA HSP, or attempted to attack the renewal of MAHSA's grant from HEW. R. Br. at 40. By this reasoning, the opportunity to seek changes in legislative standards would render unnecessary rights of appeal for adjudicative decisions. This is a novel doctrine of administrative law which would certainly attract considerable attention if broadly advanced. Even in this fact situation, however, the notion falls of its own weight. It is hardly practical for a single new hospital to carry the burden of attacking the entire HSP, or the HSA's overall performance, when the issue is what amounts to a single adjudicative decision made by private parties. As pointed out in our Brief (Pet. Br. at 33 n. 30), this Court has often identified the lack of opportunity for judicial review as a basis for determining whether implied repeal is appropriate. In this fact situation, the instant litigation is the only realistic opportunity for any judicial review of respondents' conduct.

[6] Even some of these 28 words are superfluous, according to respondents. They interpret the phrase "to the extent practicable" as merely indicating Congressional recognition of the limits on the ability of the HSA to elicit cooperation. R. Br. at 25 n. 20. It seems more likely, as we argue in our Brief (Pet. Br. at 20-21), that this phrase recognizes limits on the kind of "assistance" private parties could legally render. Nevertheless, accepting *arguendo* respondents' interpretation, this further illustrates the frail foundation on which this "special species of regulation" rests. R. Br. at 26.

II. THE 1979 AMENDMENTS ARE INCONSISTENT WITH RESPONDENTS' POSITION.

In 1977, Congress began to reexamine the 1974 Planning Act. Legislation was passed by the Senate in 1978, but was not then acted upon by the House. Finally, in 1979 Congress passed the Health Planning and Resources Development Amendments of 1979 ("1979 Amendments").

The 1979 Amendments were an attempt to build on the 1974 Act — an attempt to "strengthen [the planning process as envisioned in the 1974 Act] — not disrupt it." S. Rep. No. 96, 96th Cong., 1st Sess. 67, *reprinted in* [1979] U.S. Code Cong. & Ad. News 1306, 1372. Thus, the debates in 1979 and the legislation which resulted are quite instructive as to the purpose of Congress just five years earlier. Respondents are nevertheless unenthusiastic about the use of the 1979 Amendments as a guide to Congressional intent in 1974, and with good reason: Antitrust questions were substantial issues during the debates on the 1979 Amendments, but those debates provide no support for an implied repeal argument. In fact, the debates clearly show that all involved in 1979 — Congress, HEW and private entities — would have been quite surprised to hear that Congress had already impliedly repealed the antitrust laws in this area, as the respondents contend here.

The first witness in the hearings on the 1979 Amendments before the House Subcommittee on Health and the Environment — which was the same subcommittee responsible for holding hearings on the 1974 Act in the House — was the Undersecretary of the Department of Health, Education and Welfare, the agency primarily responsible for administering the 1974 Act. Undersecretary Hale Champion was there to present the

views of his agency on the proposed amendments to the Planning Act, and during his testimony, the following instructive dialogue occurred:

> Mr. Lee. The question concerning antitrust implications, could you comment on that? Do we need to exempt HSA's? There seem to be too few legal precedents on the surface to make that kind of judgment.
>
> Mr. Champion. Our view is that the concern . . . is misplaced. The problem of antitrust here is if the agency attempts to delegate its responsibility to some group by saying to hospitals, you divide up this responsibility. If the agency itself considers the questions and makes the decisions based on an institution's specific kind of data, then we don't think there are any antitrust questions involved.
>
> It is only when there is an indication that the decision was reached by letting some providers get together and allocate functions. But if the agency looks at it, makes a decision based on its own review, and doesn't delegate the responsibility to a group of providers, then there aren't antitrust questions.
>
> I think in some cases there has been an effort to make people more worried about that subject than they ought to be. That is our present view. [Health Planning and Resources Development Amendments of 1979: Hearings before the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce on H.R. 3041 and H.R. 3107, 96th Cong., 1st Sess. 161 (1979) (hereinafter "Hearings on 1979 Health Planning Amendments")].

If the Congress in 1974 intended to repeal the antitrust laws, this significant fact had obviously escaped the attention of both the agency administering the Planning Act and the subcommittee responsible for the legislation.

The testimony of private witnesses on the 1979 Amendments similarly negates any notion that they believed that antitrust laws had been repealed by the 1974 Act. The American Health Planning Association urged the addition of an antitrust exemption for planning agencies and those "who voluntarily follow the recommendations of a SHPDA or HSA . . . ." Hearings on 1979 Health Planning Amendments, at 188. The American Medical Association recommended that "actions taken in meeting the requirements of the Act" be exempt from the antitrust laws. *Id.* at 641. The Health Insurance Association of America urged that Congress "make clear that the health planning agencies in the execution of their responsibilities concerning voluntary conversion, closure, reduction of capacity, and development of multi-institutional systems are exempt from antitrust action if those activities are carried out in compliance with the planning law." *Id.* at 671. The Central Virginia Health Systems Agency suggested that Congress "exempt HSAs and providers who voluntarily work with them in carrying out the HSA's statutory authority from the anti-trust laws." *Id.* at 701. This record of continual suggestions for *explicit* antitrust exemptions cannot be reconciled with the argument that Congress had, just five years earlier, created an *implied* antitrust exemption. Certainly those most active in the field had no such understanding in 1979.

The Congressional discussions are even more revealing. The Senate Report, in discussing the inclusion of the "strengthening of competitive forces in the health services industry" as an additional health priority, expressed concern about the creation of "industry cartels which emphasize market stability rather than innovation and consumer preference," and served notice that it "intends to protect against such tendencies in health sector

regulation." S. Rep. No. 96, 96th Cong., 1st Sess. 85, *reprinted in* [1979] U.S. Code Cong. & Ad. News 1306, 1390. The House Report devoted over five pages to "The Role of Competition . . . and the Application of the Antitrust Laws . . .," seeking, in its words, "to explain the appropriate relationship between [the 1974 Act] and the antitrust laws and the appropriate interaction between health planning and competition." H.R. Rep. No. 190, 96th Cong., 1st Sess. 51 (1979). Neither report contains even a single reference to antitrust immunity for private parties "cooperating" with planning agencies. It strains credulity to imagine that the 1974 Congressional intention respondents see so clearly in 1981 was never mentioned or even alluded to in 1979.

What Congress actually did in 1979 is also instructive. The 1974 Act included a limited exemption from private damage actions for individual members and employees of HSAs; there was no mention of any exemption for private parties outside of HSAs. As we have seen, the scope of this exemption was a major issue in 1979. Several recommendations would have extended the statute's express immunity to include private parties "cooperating" with planning agencies. Congress rejected those suggestions, broadening the express exemption only to include the HSA itself and to include a good faith defense for HSA employees and members. No exemption was provided for private parties, nor is there one iota of evidence that Congress thought such an exemption was unnecessary because it already existed.

III. THE NOTION OF ANTITRUST IMMUNITY WITHOUT EFFECTIVE PUBLIC SUPERVISION FINDS NO SUPPORT IN PRIOR DECISIONS OF THIS COURT.

There is no doubt that federal and state governments, within the concept of federalism set forth in the Constitution, can restrain competition and restrict market liberty. Where the power to restrain competition is consigned to private interests with economic stakes in the outcome, however, serious constitutional questions are raised. *See, e.g., Schechter Corp.* v. *United States,* 295 U.S. 495 (improper delegation of legislative powers); *Gibson* v. *Berryhill,* 411 U.S. 564, 578-79 (regulation by those with pecuniary interest in the outcome is denial of due process).[7]

This same issue — the delegation of government power — has also been faced in the context of the "state action" exemption cases (which respondents, for obvious reasons, argue are not relevant).[8] Under the "state ac-

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[7] Respondents in effect argue that Congress in enacting the 1974 Planning Act intended to delegate to private parties unlimited power to adopt whatever measures they thought conducive to furthering the general congressional goals of "restraining increases in the cost of providing . . . health services," and "preventing unnecessary duplication of health resources." 42 U.S.C. §300*l*-2(a)(3)&(4). If this is so, the delegated power here, like that in *Schechter*, is, in Justice Cardozo's words, "not canalized within banks that keep it from overflowing." Rather, it is "unconfined and vagrant," unrestrained by any standard to which it must conform (295 U.S. at 551-52, Cardozo, J., concurring.) *See also Carter* v. *Carter Coal Co.*, 298 U.S. 238, 311.

[8] Respondents' protests of irrelevance (R. Br. at 29, 35) ignore the fact that the only *regulatory* scheme established by the 1974 Act was a scheme of state regulation. Respondent argues that "[t]o require compulsion as a prerequisite to antitrust immunity here would be to destroy the chances for any regulatory scheme based on

tion" doctrine, it is not enough that market restraints are "prompted" by the State as sovereign or imposed by "state agenc[ies] for limited purposes." *Goldfarb* v. *Virginia State Bar,* 421 U.S. 773, 791. Rather the sovereign command must be clear and subject to the "pointed re-examination" of authorized public bodies. *Bates* v. *State Bar of Arizona,* 433 U.S. 350, 362.

That does not mean that interested private parties cannot have an important voice in a market-restraining regulatory process. Government depends, in many cases, on access to information from private parties, *see Eastern Railroad Presidents Conference* v. *Noerr Motor Freight, Inc.,* 365 U.S. 127, 137, and a public scheme of regulation is not barred merely because it is triggered by private action, *see Parker* v. *Brown,* 317 U.S. 341; *New Motor Vehicle Board of California* v. *Orrin W. Fox Co.,* 439 U.S. 96. Yet in the end, there must be a clear *public* mandate and clear *public* supervision. *California Retail Liquor Dealers Association* v. *Midcal Aluminum, Inc.,* 445 U.S. 97. This is not, as this short discussion shows, an isolated legal principle, but a basic application of the rule of law — which abhors the vigilante tradition.[9] It is

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cooperative implementation ever to succeed." (R. Br. at 35). But is this anything more than the discredited notion that to require active supervision by the State would destroy the opportunity to "give immunity to those who violate the Sherman Act by authorizing them to violate it. . . ."? *See Parker* v. *Brown,* 317 U.S. 341, 351; *California Retail Liquor Dealers Ass'n* v. *Midcal Aluminum, Inc.,* 445 U.S. 97. "Cooperative implementation," as that phrase is used by respondents, is directly inconsistent with the language and spirit of the antitrust laws and, like the attempted delegation of governmental power to private parties by the States, should not be countenanced by this Court in the absence of "clear and manifest" evidence that Congress intended such a result. *See* authorities cited, Pet. Br. at 14. No such evidence can be found here.

[9] Respondents claim that this case is "worlds apart from *Fashion Originators Guild* v. *FTC,* 312 U.S. 457, where an industry group

also the teaching of the federal implied immunity cases which, even when they find immunity, turn on the responsibility, role and supervision of the *public* actor.

Respondents seek to find support in *United States* v. *National Association of Securities Dealers, Inc.*, 422 U.S. 694, and *Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659. Petitioner agrees these are useful comparisons, although they compel quite a different conclusion from that urged by respondents. In *NASD*, the Court was faced with a statute which "vests in the SEC broad regulatory authority over the business practices of investment companies." 422 U.S. at 704-05 & n.13. In that context, and after a very careful review of the language and legislative history of the statute involved, the Court concluded that the agreements challenged as violations were contemplated by Congress when it enacted the legislation, "for we see no way to reconcile *the Commission's power to authorize these restrictions* with the competing mandate of the antitrust laws." 422 U.S. at 722, emphasis added. The Court reasoned that (422 U.S. at 729-30):

> Congress had made a judgment that these restrictions on competition might be necessitated by the

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acted as legislature, judge and jury." R. Br. at 39. Yet, that is exactly what Blue Cross did. By respondents' own admission, Blue Cross was an active member of MAHSA, and itself helped develop the Health Systems Plan, which provided the "standards" by which Blue Cross sought to bar National Gerimedical's entry into the market. R. Br. at 38. Much though respondents would like to have this Court conclude that they were merely implementing independently-arrived-at community standards (R. Br. at 39), Blue Cross itself had a major role in helping to draw up those standards. Under these circumstances, to argue that Blue Cross' activity was passive, and directed only to implementing need standards independently arrived at by MAHSA, is disingenuous. In short, Blue Cross is acting, in a very real sense, as "legislature, judge and jury."

> unique problems of the mutual-fund industry, and has vested in the SEC final authority to determine whether and to what extent they should be tolerated 'in the interests of the holders of all the outstanding securities' of mutual funds.
>
> The SEC, *the federal agency responsible for regulating the conduct of the mutual-fund industry,* urges that *its authority* will be compromised seriously if these agreements are deemed actionable under the Sherman Act. We agree. There can be no reconciliation of *its authority under §22(f) to permit* these and similar restrictive agreements with the Sherman Act's declaration that they are illegal *per se.* In this instance the antitrust laws must give way if the regulatory scheme established by the Investment Company Act is to work. *Silver* v. *New York Stock Exchange,* 373 U.S. 341 (1963). [Emphasis added, footnote and citation omitted.]

Thus, the key fact was the authority of the SEC, a public agency, to oversee and regulate the conduct under attack. Respondents' attempt to equate MAHSA to the SEC is not convincing. The SEC is a federal agency invested with broad regulatory powers; MAHSA is a private corporation, comprised of providers, consumers and other interest groups, with no regulatory powers of any kind.[10] The SEC has the power to promulgate rules

[10] In 1979, Congress added new conflict of interest provisions to those already in the Planning Act to prevent providers from voting on matters before an HSA in which they had a financial interest. Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, §113(b), 93 Stat. 606, codified at 42 U.S.C. §300m-3(e) (Supp. III 1979). The concerns underlying this and earlier similar actions illustrate the fundamentally different character of an HSA from that of a public agency like the SEC. These concerns would be superfluous if Congress was trying to encourage private unsupervised arrangements by providers and others. Conflict of interest provisions are minor matters indeed if private collusion is to be the order of the day.

and regulations, and impose its will on those subject to its mandate; MAHSA has no power to do anything other than collect data and make recommendations. To the extent the 1974 Act created any regulatory agency, it is the SHPDA; under the Act, only the SHPDA can bar entry or expansion, and then only through application of the State certificate of need statute. The argument that the application of the antitrust laws would impose conflicting or inconsistent standards on Blue Cross is particularly disingenuous here, where the State — the only entity with any power under the legislative scheme to impose any standards on anyone — at the relevant time imposed no requirements and has now approved the very conduct that Blue Cross is seeking to impede.[11]

Nor is *Gordon* helpful to respondents' position. There again the Court was faced with legislation providing "explicit statutory authorization for SEC review of all exchange rules and practices dealing with rates of commission and resultant SEC continuing activity." 422

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[11] The assertion by respondents that "[p]etitioner cannot escape the provisions of the 1974 Act merely because the State of Missouri hesitated in enacting its own legislation" (R. Br. at 29) emphasizes the difficulties inherent in respondents' argument. The State of Missouri, like all other states, had the option to create a certificate of need program or face loss of federal funds. Until 1978, when it adopted certificate of need legislation, Missouri chose the latter course. Respondents are forced to argue, despite this choice by the State of Missouri and despite the fact that when Missouri did promulgate certificate of need legislation it granted approval to petitioner, that Congress intended a purely private group of individuals and entities to have the power, with no oversight or review by any public body, to veto decisions made by the State of Missouri in its sovereign capacity. For respondents to prevail, this Court must accept not only that this is what Congress intended, but that it created such a peculiar program without ever once debating its merits.

U.S. at 685. The very language quoted by respondents (R. Br. at 37), with changed emphasis, clearly illustrates the difference between that situation and the one here (422 U.S. at 689-90):

> It is clear . . . that the commission rate practices of the exchanges *have been subjected to the scrutiny and approval of the SEC.* If antitrust courts were to impose different standards or requirements, the exchanges might find themselves unable to proceed without violation of the mandate of the courts *or of the SEC.* Such different standards are likely to result because the sole aim of antitrust legislation is to protect competition, whereas the SEC must consider, in addition, the economic health of the investors, the exchanges, and the securities industry. *Given the expertise of the SEC, the confidence the Congress has placed in the agency, and the active roles the SEC and the Congress have taken,* permitting courts throughout the country to conduct their own antitrust proceedings would conflict with the regulatory scheme authorized by Congress rather than supplement that scheme. [Emphasis added; footnotes omitted].

Here, by contrast, there is no agency able to examine or approve the conduct in question; there has been no scrutiny of any kind of the boycott by Blue Cross, much less any approval by any public agency; no mandate of any public agency requires Blue Cross' conduct; there are no "different standards"; and there is no possibility that antitrust enforcement against private collusive conduct in such circumstances would "conflict with the regulatory scheme authorized by Congress."

In *NASD* and *Gordon*, the Court was faced with antitrust attacks on self-regulatory schemes clearly and affirmatively accepted by Congress, subject to the active and continuing oversight of a public agency with the power to approve, prohibit or alter the actions complain-

ed of. Here, there is no such scheme of self-regulation; there is no public agency with the power to approve or regulate in any way the conduct complained of; and respondents concede that their actions were volitional and independent of any regulatory compulsion. These differences are critical, and thus *NASD* and *Gordon* provide no support for a conclusion of implied repeal.

CONCLUSION

Congress never exempted the conduct at issue from the antitrust laws, either explicitly or by implication. The judgment below should be reversed.

Respectfully submitted,

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APPENDIX

APPENDIX

Relevant Statutory Provisions Of The National Health Planning And Resources Development Act Of 1974
[Excerpted from the 1976 Codification of the Act, 42 U.S.C. §§300k *et seq.* (1976)]

Section 300*l*-1(b)(1)

(b) Legal structure; staff; governing body; responsibilities; composition; limitation of individual liability; acceptance of contributions; reports

(1) A health systems agency for a health service area shall be—

(A) a nonprofit private corporation (or similar legal mechanism such as a public benefit corporation) which is incorporated in the State in which the largest part of the population of the health service area resides, which is not a subsidiary of, or otherwise controlled by, any other private or public corporation or other legal entity, and which only engages in health planning and development functions;

(B) a public regional planning body if (i) it has a governing board composed of a majority of elected officials of units of general local government or it is authorized by State law (in effect before January 4, 1975) to carry out health planning and review functions such as those described in section 300*l*-2 of this title, and (ii) its planning area is identical to the health service area; or

(C) a single unit of general local government if the area of the jurisdiction of that unit is identical to the health service area.

A health systems agency may not be an educational institution or operate such an institution.

Section 300*l*-2(b)

(b) Health Systems and Annual Implementation Plans; establishment; review

In providing health planning and resources development for its health service area, a health systems agency shall perform the following functions:

(1) The agency shall assemble and analyze data concerning—

(A) the status (and its determinants) of the health of the residents of its health service area,

(B) the status of the health care delivery system in the area and the use of that system by the residents of the area,

(C) the effect the area's health care delivery system has on the health of the residents of the area,

(D) the number, type, and location of the area's health resources, including health services, manpower, and facilities

(E) the patterns of utilization of the area's health resources, and

(F) The environmental and occupational exposure factors affecting immediate and long-term health conditions.

In carrying out this paragraph, the agency shall to the maximum extent practicable use existing data (including data developed under Federal health programs) and coordinate its activities with the cooperative system provided for under section 242k(e) of this title

(2) the agency shall, after appropriate consideration of the recommended national guidelines for health planning policy issued by the Secretary under section 300k-1 of this title, the priorities set forth in section 300k-2 of this title, and the data developed pursuant to paragraph (1), establish, annually review, and amend as necessary a health systems plan (hereinafter in this subchapter referred to as the "HSP") which shall be a detailed statement of goals (A) describing a healthful environment and health systems in the area which, when developed, will

assure that quality health services will be available and accessible in a manner which assures continuity of care, at reasonable cost, for all residents of the area; (B) which are responsive to the unique needs and resources of the area; and (C) which take into account and is consistent with the national guidelines for health planning policy issued by the Secretary under section 300k-1 of this title respecting supply, distribution, and organization of health resources and services. Before establishing an HSP, a health systems agency shall conduct a public hearing on the proposed HSP and shall give interested persons an opportunity to submit their views orally and in writing. Not less than thirty days prior to such hearing, the agency shall publish in at least two newspapers of general circulation throughout its health service area a notice of its consideration of the proposed HSP, the time and place of the hearing, the place at which interested persons may consult the HSP in advance of the hearing, and the place and period during which to submit written comments to the agency on the HSP.

(3) The agency shall establish, annually review, and amend as necessary an annual implementation plan (hereinafter in this subchapter referred to as the "AIP") which describes objectives which will achieve the goals of the HSP and priorities among the objectives. In establishing the AIP, the agency shall give priority to those objectives which will maximally improve the health of the residents of the area, as determined on the basis of the relation of the costs of attaining such objectives to their benefits, and which are fitted to the special needs of the area.

(4) The agency shall develop and publish specific plans and projects for achieving the objectives established in the AIP.

Section 300*l*-2(f)

(f) Recommendations for new institutional health services.

To assist State health planning and development agencies in carrying out their functions under paragraphs (4) and (5) of section 300m-2(a) of this title each health systems agency shall review and make recommendations to the appropriate State health planning and development agency respecting the need for new institutional health services proposed to be offered or developed in the service area of such health systems agency.

Section 300*l*-2(g)(1) and (2)

(g) Institutional health services, review

(1) Except as provided in paragraph (2), each health systems agency shall review on a periodic basis (but at least every five years) all institutional health services offered in the health service area of the agency and shall make recommendations to the State health planning and development agency designated under section 300m of this title for each State in which the health systems agency's health service area is located respecting the appropriateness in the area of such services.

(2) A health systems agency shall complete its initial review of existing institutional health services within three years after the date of the agency's designation under section 300*l*-4(c) of this title

Section 300*l*-2(h)

(h) Recommendations of projects to state health planning and development agencies

Each health systems agency shall annually recommend to the State health planning and development agency designated for each State in which the health systems agency's health service area is located (1) projects for the modernization, construction, and conversion of medical facilities in the agency's health service area which projects will achieve the HSP and AIP of the health systems agency, and (2) priorities among such projects

Section 300m

§300m. Designation of State health planning and development agencies

(a) Authority of Secretary to enter into agreements

For the purpose of the performance within each State of the health planning and development functions prescribed by section 300m-2 of this title, the Secretary shall enter into and renew agreements (described in subsection (b) of this section) for the designation of a State health planning and development agency for each State other than a State for which the Secretary may not under subsection (d) of this section enter into, continue in effect, or renew such an agreement.

(b) State administrative program; Governor as the authority to select agency; requirements; conditional designation; period of agreement; termination; designation of State agency for the State; termination and renewal

(1) A designation agreement under subsection (a) of this section is an agreement with the Governor of a State for the designation of an agency (selected by the Governor) of the government of that State as the State health planning and development agency (herinafter in this part referred to as the "State Agency") to administer the State administrative program prescribed by section 300m-1 of this title and to carry out the State's health planning and development functions prescribed by section 300m-2 of this title. The Secretary may not enter into such an agreement with the Governor of a State unless —

(A) there has been submitted by the State a State administrative program which has been approved by the Secretary,

(B) an application has been made to the Secretary for such an agreement and the application contains assurances satisfactory to the Secretary that the agency selected by the Governor for designation as the State Agency has the authority and resources to administer the State administrative program of the State and to carry out the health planning and development functions prescribed by section 300m-2 of this title, and

(C) in the case of an agreement entered into under paragraph (3), there has been established for the State a Statewide Health Coordinating Council meeting the requirements of section 300m-3 of this title.

(2)(A) The agreement entered into with a Governor of a State under subsection (a) of this section may provide for the designation of a State Agency on a conditional basis with a view to determining the capacity of the designated State Agency to administer the State administrative program of the State and to carry out the health planning and development functions prescribed by section 300m-2 of this title. The Secretary shall require as a condition to the entering into of such an agreement that the Governor submit on behalf of the agency to be designated a plan for the agency's orderly assumption and implementation of such functions.

(B) The period of an agreement described in subparagraph (A) may not exceed twenty-four months. During such period the Secretary may require that the designated State Agency perform only such of the functions of a State Agency prescribed by section 300m-2 of this title as he determines it is capable of performing. The number and type of such functions shall, during such period, be progressively increased as the designated State Agency becomes capable of added responsibility, so that by the end of such period the designated State Agency may be considered for designation under paragraph (3),

(C) Any agreement with a Governor of a State entered into under subparagraph (A) may be terminated by the Governor upon ninety day's notice to the Secretary or by the Secretary upon ninety days' notice to the Governor.

(3) If, on the basis of an application for designation as a State Agency (and, in the case of an agency conditionally designated under paragraph (2), on the basis of its performance under an agreement with a Governor of a State entered into under such paragraph), the Secretary determines that the agency is capable of fulfilling, in a satisfactory manner, the

responsibilities of a State Agency, he shall enter into an agreement with the Governor of the State designating the agency as the State Agency for the State. No such agreement may be made unless an application therefor is submitted to, and approved by, the Secretary. Any such agreement shall be for a term of not to exceed twelve months, except that, prior to the expiration of such term, such agreement may be terminated —

(A) by the Governor at such time and upon such notice to the Secretary as he may by regulation prescribe, or

(B) by the Secretary, at such time and upon such notice to the Governor as the Secretary may by regulation prescribe, if the Secretary determines that the designated State Agency is not complying with or effectively carrying out the provisions of such agreement. An agreement under this paragraph shall contain such provisions as the Secretary may require to assure that the requirements of this part respecting State Agencies are complied with.

(4) An agreement entered into under paragraph (3) for the designation of a State Agency may be renewed by the Secretary for a period not to exceed twelve months if he determines that it has fulfilled, in a satisfactory manner, the responsibilities of a State Agency during the period of the agreement to be renewed and if the applicable State administrative program continues to meet the requirements of section 300m-1 of this title.

(c) Agreements for substitution

If a designation agreement with the Governor of a State entered into under subsection (b)(2) or (b)(3) of this section is terminated before the date prescribed for its expiration, the Secretary shall, upon application and in accordance with subsection (b)(2), or (b)(3) of this section (as the Secretary determines appropriate), enter into another agreement with the Governor for the designation of a State Agency.

(d) Suspension of grants

If, upon the expiration of the fourth fiscal year which begins after 1975, an agreement under this section for the

designation of a State Agency for a State is not in effect, the Secretary may not make any allotment, grant, loan, or loan guarantee, or enter into any contract, under this chapter, the Community Mental Health Centers Act [42 U.S.C. 2689 et seq.], or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 [42 U.S.C. 4541 et seq.] for the development, expansion, or support of health resources in such State until such time as such an agreement is in effect.

Section 300m

§300m. Designation of State health planning and development agencies

(a) Authority of Secretary to enter into agreements

For the purpose of the performance within each State of the health planning and development functions prescribed by section 300m-2 of this title, the Secretary shall enter into and renew agreements (described in subsection (b) of this section) for the designation of a State health planning and development agency for each State other than a State for which the Secretary may not under subsection (d) of this section enter into, continue in effect, or renew such an agreement.

(b)State administrative program; Governor as the authority to select agency; requirements; conditional designation; period of agreement; termination; designation of State agency for the State; termination and renewal

(1) A designation agreement under subsection (a) of this section is an agreement with the Governor of a State for the designation of an agency (selected by the Governor) of the government of that State as the State health planning and development agency (hereinafter in this part referred to as the "State Agency") to administer the State administrative program prescribed by section 300m-1 of this title and to carry out the State's health planning and development functions prescribed by section 300m-2 of this title. The Secretary may not enter into such an agreement with the Governor of a State unless —

(A) there has been submitted by the State a State administrative program which has been approved by the Secretary,

(B) an application has been made to the Secretary for such an agreement and the application contains assurances satisfactory to the Secretary that the agency selected by the Governor for designation as the State Agency has the authority and resources to administer the State administrative program of the State and to carry out the health planning and development functions prescribed by section 300m-2 of this title, and

(C) in the case of an agreement entered into under paragraph (3), there has been established for the State a Statewide Health Coordinating Council meeting the requirements of section 300m-3 of this title.

Section 300m-1

§300m-1. State administrative program

(a) Conditions for approval by Secretary

A State administrative program (hereinafter in this section referred to as the "State Program") is a program for the performance within the State by its State Agency of the functions prescribed by Section 300m-2 of this title. The Secretary may not approve a State Program for a State unless it —

(1) meets the requirements of subsection (b) of this section;

(2) has been submitted to the Secretary by the Governor of the State at such time and in such detail, and contains or is accompanied by such information, as the Secretary deems necessary; and

(3) has been submitted to the Secretary only after the Governor of the State has afforded to the general public of the State a reasonable opportunity for a presentation of views on the State Program.

(b) Requisite features of program

The State Program of a State must —

(1) provide for the performance within the State (after the designation of a State Agency and in accordance with the designation agreement) of the functions prescribed by section 300m-2 of this title and specify the State Agency of the State as the sole agency for the performance of such functions (except as provided in subsection (b) of such section) and for the administration of the State Program;

(2) contain or be supported by satisfactory evidence that the State Agency has under State law the authority to carry out such functions and the State Program in accordance with this part and contain a current budget for the operation of the State Agency;

(3) provide for adequate consultation with, and authority for, the Statewide Health Coordinating Council (prescribed by section 300m-3 of this title), in carrying out such functions and the State Program;

(4)(A) set forth in such detail as the Secretary may prescribe the qualifications for personnel having responsibilities in the performance of such functions and the State Program, and require the State Agency to have a professional staff for planning and a professional staff for development, which staffs shall be of such size and meet such qualifications as the Secretary may prescribe.

(B) provide for such methods of administration as are found by the Secretary to be necessary for the proper and efficient administration of such functions and the State Program, including methods relating to the establishment and maintenance of personnel standards on a merit basis consistent with such standards as are or may be established by the Civil Service Commission under section 4728(a) of this title, but

the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with the methods relating to personnel standards on a merit basis established and maintained in conformity with this paragraph;

(5) require the State Agency to preform its functions in accordance with procedures and criteria established and published by it, which procedures and criteria shall conform to the requirements of section 300n-1 of this title;

(6) require the State Agency to (A) conduct its business meetings in public,(B) give adequate notice to the public of such meetings, and (C) make its records and data available, upon request, to the public;

(7) (A) Provide for the coordination (in accordance with regulations of the Secretary) with the cooperative system provided for under section 242k(e) of this title of the activities of the State Agency for the collection, retrieval, analysis, reporting, and publication of statistical and other information related to health and health care, and (B) require providers of health care doing business in the State to make statistical and other reports of such information to the State Agency;

(8) provide, in accordance with methods and procedures prescribed or approved by the Secretary, for the evaluation, at least annually, of the performance by the State Agency of its functions and of their economic effectiveness;

(9) provide that the State Agency will from time to time, and in any event not less often than annually, review the State Program and submit to the Secretary required modifications;

(10) require the State Agency to make such reports, in such form and containing such information, con-

cerning its structure, operations, performance of functions, and other matters as the Secretary may from time to time require, and keep such records and afford such access thereto as the Secretary may find necessary to verify such reports;

(11) require the State Agency to provide for such fiscal control and fund accounting procedures as the Secretary may require to assure proper disbursement of, and accounting for, amounts received from the Secretary under this subchapter;

(12) permit the Secretary and the Comptroller General of the United States, or their representatives, to have access for the purpose of audit and examination to any books, documents, papers, and records of the State Agency pertinent to the disposition of amounts received from the Secretary under this subchapter; and

(13) provide that if the State Agency makes a decision in the performance of a function under paragraph (3), (4), (5), or (6) of section 300m-2(a) of this title or under subchapter XIV of this chapter which is inconsistent with a recommendation made under subsection (f), (g), or (h) of section 300*l*-2 of this title by a health systems agency within the State —

(A) such decision (and the record upon which it was made) shall, upon request of the health systems agency, be reviewed, under an appeals mechanism consistent with State law governing the practices and procedures of administrative agencies, by an agency of the State (other than the State health planning and development agency) designated by the Governor, and

(B) the decision of the reviewing agency shall for purposes of this subchapter and subchapter XIV of this chapter be considered the decision of the State health planning and development agency.

(c) Review by Secretary

The Secretary shall approve any State Program and any modification thereof which complies with subsections (a) and (b) of this section. The Secretary shall review for compliance with the requirements of this part the specifications of and operations under each State Program approved by him. Such review shall be conducted not less often than once each year.

Section 300m-2

§300m-2. State health planning and development functions

(a) Performance by State agency of a State designated under section 300m(b) (3) of this title.

Each State Agency of a State designated under section 300m(b)(3) of this title shall, except as authorized under subsection (b) of this section, perform within the State the following functions:

(1) Conduct the health planning activities of the State and implement those parts of the State health plan (under section 300m-3(c)(2) of this title) and the plans of the health systems agencies within the State which relate to the government of the State.

(2) Prepare and review and revise as necessary (but at least annually) a preliminary State health plan which shall be made up of the HSP's of the health systems agencies within the State. Such preliminary plan may, as found necessary by the State Agency, contain such revisions of such HSP's to achieve their appropriate coordination or to deal more effectively with state-wide health needs. Such preliminary plan shall be submitted to the Statewide Health Coordinating Council of the State for approval or disapproval and for use in developing the State health plan referred to in section 300m-3(c) of this title.

(3) Assist the Statewide Health Coordinating Council of the State in the review of the State medical facilities plan required under section 300o-2 of this title, and in the performance of its functions generally.

(4)(A) Serve as the designated planning agency of the State for the purpose of section 1320a-1 of this title if the State has made an agreement pursuant to such section, and (B) administer a State certificate of need program which applies to new institutional health services proposed to be offered or developed within the State and which is satisfactory to the Secretary. Such program shall provide for review and determination of need prior to the time such services, facilities, and organizations are offered or developed or substantial expenditures are undertaken in preparation for such offering or development, and provide that only those services, facilities, and organizations found to be needed shall be offered or developed in the State. In performing its functions under this paragraph the State Agency shall consider recommendations made by health systems agencies under section 3001-2(f) of this title.

(5) After consideration of recommendations submitted by health systems agencies under section 300*l*-2(f) of this title respecting new institutional health services proposed to be offered within the State, make findings as to the need for such services.

(6) Review on a periodic basis (but not less often than every five years) all institutional health services being offered in the State and, after consideration of recommendations submitted by health systems agencies under section 300*l*-2(g) of this title respecting the appropriateness of such services, make public its findings.

(b) Performance by other State agencies

(1) Any function described in subsection (a) of this section may be performed by another agency of the State government upon request of the Governor under an agreement with the State Agency satisfactory to the Secretary.

(2) The requirement of paragraph (4)(B) of subsection (a) of this section shall not apply to a State

Agency of a State until the expiration of the first regular session of the legislature of such State which begins after January 4, 1975.

(3) A State Agency shall complete its findings with respect to the appropriateness of any existing institutional health service within one year after the date of a health systems agency has made its recommendation under section 300*l*-2(g) of this title with respect to the appropriateness of the service.

(c) Statement

If a State Agency makes a decision in carrying out a function described in paragraph (4), (5), (6), or (7) of subsection (a) of this section which is not consistent with the goals of the applicable HSP or the priorities of the applicable AIP, the State Agency shall submit to the appropriate health systems agency a detailed statement of the reasons for the inconsistency.

No. 80-802

IN THE

MAR 19 1981

ALEXANDER L. STEVAS,
CLERK

Supreme Court of the United States

October Term, 1980

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER, a Missouri Not-For-Profit Corporation,

Petitioner,

v.

BLUE CROSS OF KANSAS CITY, a Missouri Corporation, and BLUE CROSS ASSOCIATION, an Illinois Corporation,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

Brief Of Federation Of American Hospitals As Amicus Curiae In Support Of Petitioner National Gerimedical Hospital And Gerontology Center

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TABLE OF CONTENTS

		PAGE
I.	INTEREST OF AMICUS CURIAE	1
II.	SUMMARY OF ARGUMENT	2
III.	ARGUMENT	3
	A. Introduction	3
	B. The National Health Planning and Resources Development Act of 1974	6
	1. Health System Agencies	6
	2. Health Planning and Development Agencies	9
	3. Statewide Health Coordinating Councils	10
	C. The Doctrine of Implied Repeal Has No Application in This Case	11
	1. There Is No "Plain Repugnancy" Between the Act and the Antitrust Laws	13
	2. Congressional Intent Does Not Support Application of the Implied Repeal Doctrine	17
	(a) The Senate Committee Report	18
	(b) The Statement of Representative Rogers	20
	3. The Court of Appeals Ignored Traditional Rules of Statutory Construction in Construing the Antitrust Laws	22
IV.	CONCLUSION	24

TABLE OF AUTHORITIES

CASES	PAGE
Abbott Laboratories v. Portland Retail Druggists, 425 U.S. 1 (1976)	16
Ballard v. Blue Shield of Southern West Virginia, Inc., 543 F.2d 1075 (4th Cir. 1976) *cert. denied,* 430 U.S. 922 (1977)	16
Cain v. Air Cargo, Inc., 599 F.2d 316 (9th Cir. 1979)	19
California Retail Liquor Dealers Assoc. v. Midcal Aluminum Inc., 445 U.S. 97 (1980)	16, 22
Cantor v. Detroit Edison Co., 428 U.S. 529 (1976)	11, 12, 14, 15
Carnation Company v. Pacific Westbound Conf., 393 U.S. 213 (1966)	11, 19, 23
Castenada-Gonzalez v. INS, 564 F.2d 417 (D.C. Cir. 1977)	21
Feminist Women's Health Center, Inc. v. Mohammed, 586 F.2d 530 (5th Cir. 1978), *cert. denied* 444 U.S. 925 (1978)	16
Federal Communications Commission v. RCA Communications, Inc., 346 U.S. 86 (1953)	11
Georgia v. Pennsylvania Railroad Co., 324 U.S. 439 (1945)	11
Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975)	16
Gordon v. New York Stock Exchange, Inc., 422 U.S. 659 (1975)	14
Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979)	12, 16
Hospital Building Co. v. Trustees of Rex Hospital, 425 U.S. 738 (1976)	2, 16
Huron Valley Hosp., Inc. v. City of Pontiac, 466 F.Supp. 130 (E.D. Mich. 1979)	17
MCI Communications Corporation v. A.T. & T., 462 F.Supp. 1072 (N.D. Ill. 1978)	12
Montgomery County, Maryland v. Califano, 449 F.Supp. 1230 (D. Md., 1978)	6

CASES — PAGE

National Gerimedical Hosp. & Gerontology Center, v. Blue Cross of Kansas City, 479 F.Supp. 1012 (W.D. Mo. 1979).....4, 5, 18

National Gerimedical Hosp. & Gerontology Center, v. Blue Cross of Kansas City, 628 F.2d 1050 (8th Cir. 1980) 5, 13, 17, 21, 22

Otter Tail Power Co. v. United States, 410 U.S. 366 (1973) 12, 15

Pan American World Airways, Inc. v. United States, 371 U.S. 296, 305 (1963) 12

Parker v. Brown, 317 U.S. 341 (1943) 22

Silver v. New York Stock Exchange, 373 U.S. 341 (1963).....12, 14

St. Paul Fire & Marine Ins. Co. v. Barry, 438 U.S. 531 (1978)..... 12

United States v. Borden Co. 23

United States v. National Ass'n of Securities Dealers, 422 U.S. 694 (1975) 11

United States v. Philadelphia National Bank, 374 U.S. 321 (1963) 11

United States v. Radio Corporation of America, 358 U.S. 334 (1959) 12, 14, 15

United States v. Sorrell, 562 F.2d 227 (3rd Cir. 1977)..... 21

United States v. Wise, 370 U.S. 405 (1962)..... 21

Waterman Steamship Corp. v. United States, 381 U.S. 252 (1965)..... 21

Wilderness Society v. Morton, 479 F.2d 842, 856 (D.C. Cir.) *cert. denied* 411 U.S. 917 (1973) 23

STATUTES

Airline Deregulation Act of 1978 P. L. 95-504, 530(a) 92 Stat. 1731 49 U.S.C. § 10706(a)(2)(A) as amended by P. L. 95-473 in 1978 (92 Stat. 1377) 19

Community Mental Health Centers Act 6, 8

Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.....6, 8

Drug Abuse Prevention, Treatment, and Rehabilitation Act, Sections 409 and 410 8

STATUTES — PAGE

Health Planning and Resources Development Amendments of 1979, P. L. 96-79, 93 Stat. 592 10
Mo. Ann. Stat. § 197.300, *et seq.* Vernon Supp. 1980 9
McCarran-Ferguson Act, 15 U.S.C. § 1012 16
Section 1502(a), Public Law 96-79 19
Section 1122 Capital Health Care Expenditures Program, 42 U.S.C. § 1320a-1 9
Sherman Act, Section 1, 15 U.S.C. § 1 4
Sherman Act, Section 2, 15 U.S.C. § 2 2
42 U.S.C. §§ 300k, *et seq.* 2
42 U.S.C. § 300k 6
42 U.S.C. § 300k-2 19
42 U.S.C. § 300l-1(b)(1)(A) 7, 10
42 U.S.C. § 300l-1(b)(3) 7
42 U.S.C. § 300l-1(b)(4)(A) 22
42 U.S.C. § 300l-1(b)(4)(A)(i) 10
42 U.S.C. § 300l-1(b)(4)(A)(ii) 10
42 U.S.C. § 300l-2(b)(2) 7
42 U.S.C. § 300l-2(b)(3) 7
42 U.S.C. § 300l-2(c)(1) 7
42 U.S.C. § 300l-2(c)(3) 7
42 U.S.C. § 300l-2(e)(1)(A) 8
42 U.S.C. § 300l-2(e)(2) 8
42 U.S.C. § 300l-2(f) 8
42 U.S.C. § 300l-2(g) 8
42 U.S.C. § 300l-2(h) 8
42 U.S.C. §§ 300m, *et seq.* 9
42 U.S.C. § 300m(d) 6
42 U.S.C. § 300m-2(a) 9
42 U.S.C. § 300m-3 10
49 U.S.C. § 1384 19
49 U.S.C. § 10706 19

MISCELLANEOUS — PAGE

Articles and Books

America's New Beginning: A Program for Economic Recovery, Feb. 18, 1981, p. 6-22 20

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1974 U.S. Code Cong. & Ad. News 7842 ..... 18, 20

1979 U.S. Code Cong. & Ad. News 1422 10

Legislative History

Congressional Record, H. 11966 (Oct. 10, 1978) 22

Hearings Before the Subcommittee on Health of Committee on Labor and Public Welfare 93rd Cong. 2nd Sess., Part I, March 11, 1974 and Part II, March 20, 26 and 28, 1974 18

H. R. Rep. No. 190, 96th Cong., 1st Sess. (1979) 19

H. R. 850—The National Health Care Reform Act of 1981 20

H. Conf. Rep. No. 1640, 93rd Cong., 2nd Sess. (1974) 18, 20

H. 5740—The Health Cost Restraint Act 20

H. R. 11488, 95th Cong., 2d Sess. (1978) 21

H. R. 16204, 93rd Cong., 2d Sess. (1974) 20

H. Rep. No. 93-1382 93rd. Cong., 2d Sess. (1974) 18

H. R. Conf. Rep. No. 96-420, 90th Cong. 1st Sess. (1979) 10

S. 1590—The Comprehensive Health Care Reform Act 20

S. 1968—The Health Incentives Reform Act 20

S. Rep. No. 93-1285 18

No. 80-802

IN THE

Supreme Court of the United States

October Term, 1980

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER, a Missouri Not-For-Profit Corporation,

Petitioner,

v.

BLUE CROSS OF KANSAS CITY, a Missouri Corporation, and BLUE CROSS ASSOCIATION, an Illinois Corporation,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

I. INTEREST OF AMICUS CURIAE

The Federation of American Hospitals (FAH) is a nonprofit corporation organized and existing under the laws of the State of New York which represents the interests of approximately 1100 investor owned acute care hospitals located throughout the United States and its possessions by means of direct membership and affiliated state associations. FAH is the recognized spokesman for such hospitals and, as such, has

received the consent of the parties hereto to file an Amicus Curiae Brief in support of petitioner National Gerimedical Hospital and Gerontology Center.[1]

FAH and its members have a direct and immediate interest in this case because the overwhelming majority of its members contract with Blue Cross plans throughout the country. Moreover, a substantial portion of FAH members are located in states which have enacted planning legislation pursuant to the National Health Planning and Resources Development Act of 1974. FAH members throughout the country, therefore, will ultimately be affected by this Court's decision.

FAH was granted permission to file an Amicus Curiae Brief in support of petitioner before the Eighth Circuit Court of Appeals. Now that the matter is before this Court, FAH again believes that, to the greatest extent practicable, a full airing of all facts, issues and arguments involved is required. Accordingly, FAH herewith files its brief as Amicus Curiae.

II. SUMMARY OF ARGUMENT

The antitrust laws represent a fundamental national economic policy that favors a competitive order prevailing in the market place. That policy may be supplanted only where Congress has expressly determined to do so, or in particular and discrete circumstances where there is a "plain repugnancy" between a congressionally enacted regulatory scheme and unfettered competition that would be required by the antitrust laws.

The regulatory scheme at issue in this case was created by the National Health Planning and Resources Development Act of 1974, 42 U.S.C. § 300k *et seq.* (hereinafter "the Act"), which was designed to facilitate the development of recommendations

[1] FAH previously appeared before this Court as an *amicus curiae* in *Hospital Building Co. v. Trustees of Rex Hospital*, 425 U.S. 738 (1976).

and resources for a national health planning policy. The Eighth Circuit Court of Appeals held that the Act contained within it the "plain repugnancy" to the antitrust laws required to find an exception to the general application of those laws to the health care industry. In so holding, it determined that voluntary actions by private health care organizations, ostensibly consistent with national health planning policies, were exempt from scrutiny under the antitrust laws.

The Eighth Circuit holding is an unwarranted and unsupported extension of the implied repeal doctrine to conduct that was neither mandated nor coerced by any statute or regulation, was not subject to review by any governmental agency and was not specifically contemplated by the Act under review. The decision by the Eighth Circuit Court of Appeals must be reversed.

III. ARGUMENT

A. Introduction

Petitioner is a Missouri not-for-profit corporation which operates a fully accredited general acute care community hospital which opened in October, 1978. Prior to commencing operation, petitioner sought a contract from respondent Blue Cross of Kansas City ("Blue Cross") in order to become a Blue Cross "participating hospital."[2]

Those hospitals which are "participating hospitals" receive 100 percent payment for covered hospital services rendered to Blue Cross subscribers. By contrast, subscribers who receive

[2] Blue Cross is a Missouri not-for-profit health care service corporation which offers its private individual and group health care plans and programs to the general public in Western Missouri and Eastern Kansas. It contracts with "participating hospitals" and with other health care providers for the provision of health care services as set forth in its various health plans.

covered services at non-participating hospitals are reimbursed only 80 percent of the hospital's charge, and reimbursement is made directly to the subscriber, rather than the hospital. Blue Cross subscribers account for approximately one-fourth of all hospital admissions in the Western Missouri and Eastern Kansas area. At the time this action was filed, with the exception of petitioner, all licensed general acute care community hospitals in the Blue Cross service area were participating Blue Cross hospitals.

Petitioner was unable to obtain a Blue Cross contract because it could not, as a condition precedent, secure the required "need approval" from Mid-America Health Systems Agency ("MAHSA"), which had previously publicly stated that it would disapprove any additional acute care hospital beds in its health service area.[3]

Because of MAHSA's public posture, petitioner did not seek "need approval" prior to submission of its application for a Blue Cross contract, and its application was, predictably, denied. Petitioner then filed the within action contending that respondents Blue Cross and BCA conspired to engage in a boycott and to coerce Blue Cross subscribers to refuse to deal with petitioner in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1. Petitioner further alleged that Blue Cross' refusal to contract with it constituted an abuse of monopoly power in violation of Section 2 of the Sherman Act, 15 U.S.C. § 2.[4]

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[3] MAHSA, organized under the Act as a health systems agency, is a private not-for-profit Missouri corporation engaged in voluntary health planning in the metropolitan Kansas City area. It had been designated by Blue Cross and Blue Cross Association ("BCA") to make determinations of "need". MAHSA had no power to enforce its "need approval" determinations, nor was it required to make such determinations under any federal or state statute or regulation.

[4] The District Court found that the conspiracy allegations were not subject to dismissal for failure to properly allege a cause of action under Section 1 of the Sherman Act. 479 F.Supp., at 1024. This finding was not reviewed by the Court of Appeals.

The District Court for the Western District of Missouri dismissed petitioner's antitrust claims on the ground that the Act impliedly repealed the antitrust laws with respect to "action taken pursuant to the Act and clearly within the scope of the Act." 479 F.Supp. 1012, 1024 (W.D.Mo. 1979). The District Court held there was a "blanket exemption" for what would otherwise be anticompetitive conduct because "voluntary cooperation of the entire health care industry, including third party payors [was] essential to the success of the Act." 479 F.Supp., at 1021.

The Court of Appeals for the Eighth Circuit affirmed, adopting in large measure the decision of the District Court. 628 F.2d. 1050 (8th Cir. 1980). The Eighth Circuit did not, however, find that the Act created a "blanket exemption", but stated that "the doctrine of implied immunity applies to Blue Cross voluntary cooperation with the congressionally designated HSA in requiring approval from MAHSA prior to applying for a Blue Cross membership contract." 628 F.2d., at 1057. The Eighth Circuit affirmation was based upon its acceptance of the District Court's review of the legislative history and finding a "clear repugnancy" between the Act and the antitrust laws, and its own finding that "the Act and regulatory scheme clearly call for the action which has now become the basis of an antitrust claim." 628 F.2d., at 1055-1056.

In so holding, however, the Court of Appeals did not find that *respondents' conduct* was mandated or coerced by any statute, regulation, or government agency activity. Similarly, the Court of Appeals did not determine that *MAHSA's conduct* was mandated or required by any statute or regulation. Finally, the Court of Appeals did not find that respondents' or MAHSA's conduct was subject to review or supervision, in any fashion, by any federal or state agency.

As will be discussed more fully, the holding of the Court of Appeals is, therefore, a radical departure from precedents established by this Court in other cases addressing the application of the implied repeal doctrine. Moreover, the Court of

Appeals' decision was not based upon an in-depth scrutiny of the interaction between the regulating agency and the antitrust actors as this Court has consistently required in implied repeal cases. Finally, the Court of Appeals' decision was based on an erroneous construction of congressional intent with respect to antitrust immunity.

B. The National Health Planning and Resources Development Act of 1974

The Act was passed by Congress to "facilitate the development of recommendations for a national health planning policy, to augment areawide and state planning for health services, manpower and facilities, and to authorize financial assistance for the development of resources to further that policy." 42 U.S.C. § 300k. To accomplish these purposes the Act established, through a series of grants made by the Department of Health, Education and Welfare (currently the Department of Health and Human Services), a voluntary nationwide system of health planning and development organizations consisting of three tiers: health system agencies (HSAs); State Health Planning and Development Agencies; and Statewide Health Coordinating Councils (SHCCs). *See generally Montgomery County, Maryland v. Califano,* 449 F.Supp. 1230 (D.Md., 1978).[5]

1. *Health System Agencies.*

The Act requires that HSAs be established for each geographic or regional area deemed appropriate for the planning and development of health services as determined by the governor of each state. An HSA may be organized as a nonprofit private corporation

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[5] It is important to emphasize that the entire health planning mechanism established by the Act is voluntary. No state is required to participate in the planning program or the scheme it establishes. Those states choosing not to participate, however, face the loss of grants, loans or contract monies available from the federal government under the Community Mental Health Centers Act and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970. 42 U.S.C. § 300m(d).

"[w]hich is not a subsidiary of, or otherwise controlled by any other private or public corporation or other legal entity and which only engages in health planning and development functions . . . ." 42 U.S.C. § 300l-1(b) 1(A).[6]

A majority (but not more than 60%) of the members of its governing body must be residents of the area who are consumers of health care and broadly representative of the population and geography in the area. The remainder of the members must also be residents of the area, but must be providers of health care representing health care institutions (such as petitioner's competitors herein), health care insurers (such as respondents herein), physicians, health professional schools and the allied health professions. 42 U.S.C. § 300l-1(b)(3).

The Act directs the HSA to function in two capacities. First, in a *pure planning* capacity, the HSA is required to:

(1) Establish long term health systems plans (HSPs) and short-term annual implementation plans (AIPs) which are statements of goals and objectives for health care planning in the health service area, 42 § 300l-2(b)(2), (3) U.S.C. § 300l-2(b)(2), (3);

(2) Implement its HSP and AIP by seeking, "to the extent practicable" the assistance of individuals and public and private entities in its health service area, 42 U.S.C. § 300l-2(c)(1);

(3) Make grants to public and private entities and enter into contracts with individuals and public and nonprofit private entities to assist them in planning and developing projects and programs determined by the HSA to be necessary, 42 U.S.C. § 300l-2(c)(3); and

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[6] The Act also allows an HSA to be a public regional planning body or a single unit of general local government. 42 U.S.C. § 300l-1(b)(1)(A), (B).

(4) Assist State Health Planning and Development Agencies in making determinations by forwarding *recommendations* to them respecting new institutional health services and projects for the modernization, construction and conversion of medical facilities in the health service area. 42 U.S.C. § 300l-2(f), (g), (h).

In essence, in its *pure planning* capacity, the HSA is directed to formulate general guidelines for health planning within its area and make recommendations to governmental agencies based upon those guidelines. *See* F. Miller, Antitrust and Certificate of Need: Health Systems Agencies, the Planning Act and Regulatory Capture, 68 Geo. L.J., 873, 883-885 (1980) (hereinafter *"Miller"*); M. K. Schonbrun, Making Certificate of Need Work, 57 N.C.L. Rev. 1259, 1277-1280 (1979).

The second capacity in which the HSA functions is the review and approval of proposed uses of federal funds under specified federal acts. 42 U.S.C. § 300l-2(e)(1)(A).[7] These decisions, unlike HSA *recommendations* made in the course of its *planning function,* may be appealed by the interested party to the Secretary. 42 U.S.C. § 300l-2(e)(2).

The Act does not require that an HSA participate in private decision making or play any adjudicatory role other than in the review and approval of proposed uses of federal funds, and then only in specified instances. The Act does not give an HSA the authority to determine whether a new health facility shall be allowed to operate, to receive funding or to contract with any party, private or governmental. That authority, to the

[7] The acts referred to are the Community Mental Health Centers Act, Sections 409 and 410 of the Drug Abuse Prevention, Treatment, and Rehabilitation Act and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

extent it is established by the Act, rests with the appropriate state health planning and development agency. *See* 42 U.S.C. § 300m-2(a).

2. *Health Planning and Development Agencies*

The second level of organization mandated by the Act is the State Health Planning and Development Agency. 42 U.S.C. §§ 300m, *et seq.* This is the agency within state government designated by the governor to perform health planning and development functions. Those functions include:

(1) The conduct of health planning activities of the state and the implementation of those parts of the State Health Plan, and the plans of the health systems agencies, which relate to the government of the state;

(2) Preparation and review as necessary of a State Health Plan which is made up of all the HSPs of the HSAs within the state; and

(3) *Service as the designated planning agency of the state to administer a certificate of need (CON) program which applies to new institutional health services to be offered or developed within the state.* 42 U.S.C. § 300m-2(a).[8]

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[8] During the period in question in this litigation (1) the State of Missouri had not enacted a Certificate of Need law to be applied to new institutional health services to be offered or developed within the state, such as petitioner's; (2) nor had Missouri designated a state agency to review and determine the need for health care facilities prior to the time facilities, such as the petitioner's, were constructed, as it was not then a participating state in the Section 1122 Capital Health Care Expenditures Program (42 U.S.C. § 1320a-1) having previously terminated its agreement for this purpose in June, 1976.

In August, 1979 Missouri enacted a Certificate of Need law (Mo. Ann. Stat. §§ 197.300 *et seq.* [Vernon Supp. 1980] which became fully effective on October 1, 1980. It provides that any "health care facility which has commenced operations prior to October 1, 1980, shall be deemed to have received a Certificate of Need. . . ." In this case, petitioner is deemed to have received state agency authority to operate. This further illustrates that MAHSA had no statutory review authority whatsoever over petitioner's ability to operate or contract.

This is the only agency mandated by the Act to make determinations of "need" for new health services, and then only through implementing state legislation.

3. *Statewide Health Coordinating Councils.*

The last tier created by the Act consists of Statewide Health Coordinating Councils (SHCCs) to coordinate the AIPs and HSPs of the HSAs and to revise, and approve or disapprove, the State Health Plan submitted by the state agency. 42 U.S.C. § 300m-3.

In addition to constructing this system to conduct health planning activities, the Act, as originally promulgated, provided immunity from damage liability for acts taken by individuals who are members or employees of an HSA:

> "[N]o individual who, as a member or employee of a health systems agency, shall, by reason of his performance of any duty, function, or activity required of, or authorized to be undertaken by, the agency under this subchapter, be liable for the payment of damages under any law of the United States or any state (or political subdivision thereof) if he has acted within the scope of such duty, function or activity, has exercised due care, and has acted, with respect to that performance, without malice toward any person affected by it." 42 U.S.C. § 300l-1(b)(4)(A)(ii).[9]

The foregoing immunity is noteworthy in several respects. First, it does not provide immunity against all liability, only from claims for monetary damage. Second, it only immunizes members or employees of the HSA from liability, not third

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[9] The Act also creates an immunity from damages for the HSA itself. 42 U.S.C. § 300l-1(b)(4)(A)(i). These immunities were amended by the Health Planning and Resources Development Amendments of 1979, P.L. 46-79, § 110(a)(1), 93 Stat. 592, to exempt activities performed without gross negligence, as well as without malice, from claims for damages. *See generally* H.R. Rep. No. 96-420 (Conf. Rep.) 90th Cong., 1st Sess., 66 (1979) *reprinted in* 1979 U.S. Code Cong. & Admin. News 1422, 1434.

parties. Third, it requires that a particular standard of care must be met for the immunity to attach.

C. The Doctrine Of Implied Repeal Has No Application In This Case

This Court has emphasized that the doctrine of implied repeal is a judicially created exemption from the application of the antitrust laws, designed to resolve clear conflicts between prohibitions contained in the antitrust laws and conduct mandated or required by other federal statutory schemes which regulate the industry in question. *Federal Communications Commission v. RCA Communications, Inc. ("RCA")*, 346 U.S. 86 (1953); *Gordon v. New York Stock Exchange, Inc. ("Gordon")*, 422 U.S. 659, 682 (1975). The doctrine is strongly disfavored and has been applied only in "particular and discrete circumstances" when the judiciary discerns that Congress, by implication, determined that the federal agency, entrusted with regulation in the public interest, could carry out its responsibilities only if it were free from the disruption of conflicting judgments that might be voiced by courts exercising jurisdiction under the antitrust laws. *United States v. National Ass'n. of Securities Dealers*, 422 U.S. 694 (1975); *Carnation Company v. Pacific Westbound Conf.*, 393 U.S. 213 (1966); *United States v. Philadelphia National Bank*, 374 U.S. 321, 350-351 (1963).

Application of the doctrine requires a finding of two elements. First, there must be a "plain repugnancy" between the antitrust laws and the regulatory provisions. *United States v. Philadelphia National Bank, supra*, 374 U.S., at 351 (1963); *Gordon, supra; Georgia v. Pennsylvania Railroad Co.*, 324 U.S. 439, 455-457 (1945). When the agency in question does not have the power to regulate the conduct in question, the doctrine cannot be applied. *Georgia v. Pennsylvania Railroad Co., supra*, 324 U.S., at 457-460 (1945); *see also Cantor v. Detroit Edison Co.*, 428 U.S. 529, 595-597, 597, fn. 37 (1976). In making this determination, an essential factor is whether the specific conduct in question was the product of regulatory

coercion or the result of the exercise of independent business judgment. Where the involved agency has not curtailed the regulated entities' activities and the conduct at issue is the product of independent business judgment, as opposed to regulatory coercion, the need to imply the immunity disappears. *See United States v. RCA,* 358 U.S. 334, 350-351 (1959); *MCI Communications Corporation v. A.T.& T.,* 462 F.Supp. 1072, 1083 (N.D.Ill. 1978), *citing Cantor v. Detroit Edison Co., supra,* 428 U.S., at 593 (1976).

The second required element is a finding of congressional intent that the regulatory scheme should prevail over the antitrust laws. If not, the immunity will not be implied. *Otter Tail Power Co. v. United States,* 410 U.S. 366, 374 (1973); *Pan American World Airways, Inc. v. United States,* 371 U.S. 296, 305 (1963).

Even where the court determines that there is a "plain repugnancy" between the regulatory scheme and the antitrust laws, the implied repeal of the antitrust laws is limited and will be extended only to the extent "necessary to make the [regulatory scheme] work." *Silver v. New York Stock Exchange,* 373 U.S. 341, 357 (1963).[10]

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[10] The extremely limited nature of implied repeal finds its corollary in this Court's construction and interpretation of express antitrust exemptions. In legislation where Congress has expressly enacted antitrust exemptions, this Court has construed them quite narrowly. For example, in *Group Life & Health Insurance Co. v. Royal Drug Co.,* 440 U.S. 205, 231 (1979), this Court narrowly interpreted the scope of the McCarran-Ferguson Act which created an antitrust exemption for specified types of insurance activities. This Court held that agreements between insurance companies and retail pharmacies affecting the price of prescriptions paid by the insurance company's policyholders were not the business of insurance and, therefore, could not be exempt from antitrust scrutiny. By contrast, the boycott exemption to the McCarran-Ferguson immunity was significantly broadened by this Court in *St. Paul Fire & Marine Ins. Co. v. Barry,* 438 U.S. 531 (1978). In that case, this Court determined that the boycott exemption should not be limited to "black-lists" of insurance companies, agents or other competitors of the boycotting group but was applicable to refusals to deal with those outside the insurance industry as well.

1. *There Is No "Plain Repugnancy" Between The Act and the Antitrust Laws.*

The conduct immunized from antitrust scrutiny by the decision of the Court of Appeals was respondents' requirement that in order to become a participating Blue Cross hospital petitioner was required to secure favorable *need review* from MAHSA. Although that conduct was not authorized, sanctioned, required or otherwise referred to in the Act, the Court of Appeals found a "clear repugnancy" between the Act which "clearly call[ed] for the action which [became] the basis of an antitrust claim" and the antitrust laws. 628 F.2d, at 1055-1056. The Court of Appeals also found that lack of state participation, at any level in the challenged conduct, did not preclude finding a "clear repugnancy" because, as the Court stated, the Act ". . . designated MAHSA as a regulatory need review agency," and ". . . calls for a regulatory system which included the designated HSA implementing the HSP and AIP 'with the assistance of individuals and public and private entities in its health service area' (citation omitted)." 628 F.2d, at 1055. The Court of Appeals categorized "the extent of [the Act's] regulatory scheme" by noting as did the District Court, the problems in health care delivery in the health service area identified in MAHSA's HSP, together with the various goals and objectives for meeting those problems.[11]

The problem with the Court of Appeals' analysis, however, is threefold. First, its characterization of MAHSA as a regulatory need review agency is erroneous. With the exception of

[11] 628 F.2d, at 1055. It is noteworthy that neither the goals of MAHSA, nor the methods for attaining those goals, as identified by the Court of Appeals, specifically prohibits hospital construction or hospital contracts with third parties (such as respondents) for the receipt of payment for services rendered. Similarly, MAHSA goals and objectives do not contain any reference to serving as a *need review* agency for respondents.

the responsibility to make certain determinations on federal funding applications not applicable herein, MAHSA has no regulatory or adjudicatory function.[12]

Second, whether MAHSA is a regulatory agency (which it is not) is not the relevant consideration. In adjudicating *need approval* for Blue Cross, MAHSA was not acting in a regulatory capacity as the Act clearly does not require, sanction or authorize HSA participation in private decision making.[13]

Further, it was not MAHSA conduct that was under review, rather it was the conduct of Blue Cross, and that conduct was neither mandated nor coerced by any federal or state legislation, nor was it subject to any review or supervision by any state or federal agency.[14]

The Court of Appeals' error is brought into sharp focus when its analysis is compared to factual situations that existed in other cases involving regulated industries where this Court rejected the application of the implied repealed doctrine. For example, in *United States v. Radio Corporation of America, supra,* this Court found defendants subject to the antitrust laws even though the action under review, an exchange of broadcasting licenses, was specifically approved by the Federal Communications Commission as being an action which met the

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[12] The only regulatory or adjudicatory agencies created by the Act, authorized to make determinations as to whether new facilities should exist, are the State Health Planning and Development Agencies.

[13] *Cf. Silver v. New York Stock Exchange,* 373 U.S. 341, 353-357 (1968). In *Silver* this Court held there could be no application of the implied repeal doctrine because the Exchange Act did not provide for agency (SEC) jurisdiction or review of the challenged conduct. Because there was no governmental oversight of the Exchange's "self-regulatory action, and no method of insuring that some attention at least was given to the public interest in competition . . ." the doctrine could not be applied. *Gordon, supra,* 422 U.S., at 683-684.

[14] *Cf. Cantor v. Detroit Edison Co., supra,* 428 U.S., at 592-593. ("This Court has already decided that state authorization, approval, encouragement, or participation in restrictive private conduct confers no antitrust immunity." [Citation omitted.])

statutory requirement that the "public interest, convenience and necessity" would be served, because the Commission had not been given the specific authority by Congress to consider antitrust issues. In *Otter Tail Power Company v. United States, supra,* this Court held that even where an agency, such as the Federal Power Commission, has the authority to consider the competitive effects of its regulatory decisions, its involvement would not immunize private party conduct from antitrust scrutiny. The Court's holding was based on the conclusion that where conduct was governed "in the first instance by business judgment and not regulatory coercion, courts must be hesitant to conclude that Congress intended to override the fundamental national policies embodied in the antitrust laws." 410 U.S., at 374.

More recently, in *Cantor v. Detroit Edison Company,* 428 U.S. 579 (1976) this Court again held that voluntary private action, even when approved by a public agency with regulatory authority, was not immune from antitrust scrutiny where the private parties' conduct was neither required, nor explicitly condoned, by the allegedly conflicting statute. This Court, therefore, rejected antitrust immunity for a private utility tariff approved by a state agency, despite the fact that the tariff, once approved, had the force and effect of law and could be changed only by seeking further approval of the state agency. 428 U.S., at 583.

In this case there has been no government agency participation, approval or acquiescence as in *RCA, Otter Tail* and *Cantor.* Instead there has been merely the voluntary private conduct of two nonprofit corporations which was not required or mandated by any law, and not subject to review or scrutiny by any state or federal agency.[15] Further, it cannot be said that

[15] The effect of the Court of Appeals' decision is also contrary to recent decisions of this Court which have had, and will have, the effect of subjecting private health care industry decisions to antitrust scrutiny. For example, in

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enforcement of the antitrust laws would interfere with MAHSA's operation. These laws neither prohibit MAHSA from continuing to implement its HSP and AIP, nor preclude it from forwarding its recommendations on new institutional health facilities to the appropriate state planning agency. The "plain repugnancy" which must exist for implied repeal to come into play, therefore, simply is not present.[16]

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Hospital Building Co. v. Trustees of Rex Hospital, 425 U.S. 738 (1976) this Court held that expansion and relocation activities of a hospital were, for antitrust jurisdictional considerations, "in interstate commerce." In the same term this Court held that the Nonprofit Institutions Act exemption from the Robinson-Patman Act for puchases of supplies by a nonprofit hospital for its "own use" would not exempt all of the hospital's drug purchases from price discrimination liabilities. *Abbott Laboratories v. Portland Retail Druggists,* 425 U.S. 1 (1976). In *Goldfarb v. Virginia State Bar,* 421 U.S. 773 (1975) this Court held that the "learned professions" were not exempt from antitrust scrutiny. In *Group Life & Health Insurance Co. v. Royal Drug,* 440 U.S. 205 (1979) this Court subjected pharmacy agreements to antitrust regulation by narrowly construing the antitrust exemption in the McCarran-Ferguson Act. Finally, in *California Retail Liquor Dealers Assoc. v. Midcal Aluminum Inc.,* 445 U.S. 97 (1980) the "state action" exemption was narrowed to require active supervision and a clearly defined state policy to confer antitrust immunity. *Cf. Feminist Women's Health Center Inc. v. Mohammed,* 586 F.2d 530, 549-550 (5th Cir. 1978), *cert. denied* 444 U.S. 925 (1978); *Ballard v. Blue Shield of Southern West Virginia, Inc.,* 543 F.2d 1075 (4th Cir. 1976), *cert. denied,* 430 U.S. 922.

[16] One commentator has pointed out that allowing HSA activity to totally escape antitrust scrutiny is particularly dangerous because of the possiblity of "regulatory capture". *Miller, supra.* As the commentator points out,

> "Indeed, competition may be more important to stimulate efficient business practices in a regulated industry context than it would be in the absence of government control. This is particularly true when, as in the health industry, regulation is fragmented rather than pervasive. The planning act's CON requirements apply only to new institutional expenditures and services and to certain major medical equipment used for inpatients. Other segments of the health industry remain untouched by supply controls. Few states, moreover, regulate rates to protect against

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2. *Congressional Intent Does Not Support Application of The Implied Repeal Doctrine*

The Court of Appeals adopted the District Court's discussion of the legislative history, and found the requisite congressional intent to immunize the voluntary private action under review from the antitrust laws. 628 F.2d, at 1056. The District Court's review, insofar as it was adopted, consists of quotations from the Senate Committee Report discussing the Act and from Representative Paul Rogers made during the

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the monopoly profits—and inefficiencies—that entry barriers may facilitate." 68 Geo. L.J., at 891-892 (citations omitted).

The same commentator, as well as others, expresses a continuing concern over the practical effect of HSA decision making on providers. While the Act encourages public participation in health planning decision making, because it permits health providers to determine whether the "need" exists for other providers' proposals it invites anticompetitive behavior. While consumers must take part in the process, because their actions do not effect their economic survival, their incentives to prevent anticompetitive behavior cannot match the motivation of providers to indulge in such activity.

The commentator also notes that some observers have predicted that CON legislation would accomplish "little more than would a hospital that sought to maximize its own welfare through a cartel." 68 Geo. L.J., at 880. *See also* J. Christianson and W. McClure, "Developing a Regulatory Strategy Consistent with a Competitive Health Care System," in *Socioeconomic Issues of Health* 1980; C. Havighurst, Regulation of Health Facilities and Services by Certificate of Need, 59 Va. L. Rev. 1143 (1973).

While at this early date in health planning it is not possible to know whether "capture" will actually occur, this Court should be reluctant to preclude from the outset any antitrust scrutiny of health planning decisions which are ostensibly made in cooperation with HSAs, particularly when the HSA is not acting in its regulatory capacity and neither the decision of the HSA, nor the private entity (in this case Blue Cross), is subject to any scrutiny or review.

course of debate in connection with a later measure.[17] Neither of these sources supports the Court of Appeals' decision; and indeed, subsequent action by Congress clearly indicates a contrary intent.

(a) The Senate Committee Report

The consequences of the Act in terms of its effect on antitrust laws was neither contemplated nor discussed at the time of its passage. Throughout the entire legislative history no mention is made of any potential conflict with antitrust regulation; in fact, the subject of antitrust was not an issue while the Act was being considered. *See* S. Rep. No. 93-1285, H. Rep. No. 93-1382, H. Conf. Rep. No. 1640, 93rd.Cong., 2nd Sess. *reprinted in* 1974 U.S. Code Cong. & Ad. News 7842 and Hearings Before The Subcommittee on Health of Committee on Labor and Public Welfare, 93rd Cong. 2nd Sess., Part I, March 11, 1974 and Part II, March 20, 26 and 28, 1974.

Although the Senate Committee expressed its concern that the health care industry did not "respond to classic market place forces," it did not in any fashion indicate that the Senate considered or attempted to exempt members of the health care industry from their legal responsibilities under the antitrust laws. *See* 1974 U.S. Code Cong. & Ad. News 7842, at 7878.

To the contrary, the debate leading to the enactment of Public Law 96-79, which amended the Act, indicates that Congress desired to preserve and foster competitive forces in

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[17] The District Court also made reference to the decision in *Huron Valley Hospital, Inc. v. City of Pontiac,* 466 F.Supp. 130 (E.D. Mich. 1979). In that case the District Court in *dicta* found the legislative history of the Act demonstrated "at least partially" congressional intent to repeal the antitrust laws. 479 F.Supp., at 1023. The Court of Appeals, however, placed no reliance on, and did not cite, the *Huron Valley Hospital* decision.

the health care industry wherever possible. This is evidenced in a number of ways. Initially, Congress mandated as a national health priority:

> "The strengthening of competitive forces in the health services industry wherever competition and consumer choice can constructively serve to advance the purposes of quality assurance, cost effectiveness, and access." Public Law 96-79, Section 1502(a) *amending* 42 U.S.C. § 300k-2.[18]

Next, legislative history indicates that Congress was well aware of the potential conflict between antitrust principles and health planning.[19] In spite of that awareness, and the fact that Congress in 1979 reviewed the immunity provisions of the Act, Congress chose not to create an antitrust immunity for the HSA or any other party who might be engaged in health planning although the precedent clearly existed for it to do so.[20]

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[18] To the same effect, Public Law 96-79 amended Section 1502 by adding the following:

> "(3) For the health services for which competition appropriately allocates supply consistent with health systems plans and State health plans, health systems agencies and state health planning and development agencies should, in the performance of their functions under this title, give priority effect of competition on the supply of such services." 42 U.S.C. § 300k-2(b)(3).

[19] Specifically, the House committee decided that the antitrust laws would not prohibit HSAs from acting within the scope of the Act. H.R. Rep. No. 190, 96th Cong., 1st Sess. 54-56 (1979).

[20] *E.g.* 49 U.S.C. § 1384 (1976), *as amended* by the Airline Deregulation Act of 1978, P.L. No. 95-504, 530(a) 92 Stat. 1731, provides that persons affected by certain orders made by the Civil Aeronautics Board shall be exempt from the operation of the "antitrust laws"; 49 U.S.C. § 10706 (a)(2)(A) *as amended* by Public Law 95-473, 92 Stat. 1377, in 1978 immunizes from the operation of the antitrust laws agreements approved by the Interstate Commerce Commission. Even where by statute Congress has immunized certain conduct approved by a regulatory agency, such as the Maritime Commission or the Civil Aeronautics Board, conduct not squarely within the four corners of the exemption remains subject to the antitrust laws. *Carnation Company v. Pacific Westbound Conf.*, 383 U.S. 213, 216-217 (1966); *Cain v. Air Cargo, Inc.*, 599 F.2d 316, 320, (9th Cir. 1979).

A further indication of the lack of congressional intent was the express rejection of a specific provision that would have mandated the conduct challenged herein. Section 1421(d) of the House passed version of the Act permitted states to require private health insurers (such as respondents), to limit payments to health provider institutions (such as petitioner) if the institution had not received a certificate of need from the state planning agency. This provision was specifically rejected in conference. *See* H.R. 16204, 93rd Cong. (1974); H. Conf. Rep. No. 1640, 93rd Cong. 2nd Sess. 78 (1974), *reprinted in* 1974 U.S. Code Cong. & Ad. News 7842, 7987. Surely it cannot be asserted that Congress intended an exemption from the anti-trust laws for voluntary health planning activity by private health care insurers, when it considered and rejected the provision which would have created the power to compel that specific result.[21]

(b) The Statement of Representative Rogers

As further support for its finding of legislative intent, great reliance was placed by the Court of Appeals (and District Court) upon the remarks of former Representative Paul Rogers made during debate on proposed amendments to the Act under

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[21] It should be noted that the new Administration has proposed total phase out for the health planning program embodied by the Act. *See,* America's New Beginning: A Program For Economic Recovery, February 18, 1981, pp. 6-22. In making this endorsement the Administration states, "If competitive forces are to restrain costs, free entry into health care markets is essential. Otherwise, high cost providers can monopolize health care markets . . ." Elimination of this franchising system is a necessary element in the Administration's efforts to promote the effective functioning of private markets forces in the health care sector." *Id.* At the moment there are a number of bills pending in Congress designed to promote competition in the health care industry. E.g., S. 1590 (The Comprehensive Health Care Reform Act); S. 1968 (The Health Incentives Reform Act); H.R. 5740 (The Health Cost Restraint Act); and H.R. 850 (The National Health Care Reform Act of 1981).

consideration in 1978. These amendments were never enacted (H.R. 11488, 95th Cong., 2nd Sess. [1978]).[22] Assuming, *arguendo,* that Mr. Rogers' remarks were an expression of congressional intent, they do not stand for the proposition expressed.[23]

While the Congressman did refer to "providers", it is clear from his remarks that he intended "provider" to mean a direct provider such as a hospital or other health care facility. He stated, that "congressional intent was for the HSA, the provider seeking the certificate of need and other providers which might seek to provide similar services to coordinate their activities to assure that new institutional health services are developed in accordance with the health systems plan for the area." 628 F.2d, at 1057. Only a health care facility (direct provider) is required to apply for a certificate of need, and only a direct provider affords "similar services". It is clear, then, that Mr. Rogers used the term "provider" as shorthand for hospital or other health care facility and not indirect providers such as respondents who do not provide health care services. Moreover, while the Court emphasized Representative Rogers' opinion that Congress intended that HSA and providers would not be subject to antitrust laws, the Court omitted the following language from the Congressman's statement which formed the basis for his belief

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[22] Because Representative Rogers statements were made during debate on amendments to the Act considered by a later Congress, but which were not enacted, the statements are of little or no significance in determining the intent of the earlier Congress which enacted the Act. *See Waterman Steamship Corp. v. United States,* 381 U.S. 252, 269 (1965); *United States v. Wise,* 370 U.S. 405, 414 (1962). Moreover, statements of legislators made during legislative discourse, but not in the context of debate on the act being construed, are entitled to little, if any, weight. *Castenada-Gonzalez v. INS* 564 F.2d 417 (D.C. Cir. 1977); *United States v. Sorrell,* 562 F.2d 227 (3rd Cir. 1977).

[23] Congressman Rogers' remarks are set forth in the Court of Appeals decision at 628 F.2d, at 1056-1057.

> "Title XV also requires that before an institution of health services is begun, the HSA must recommend to the state health planning agency whether the institutional health services is needed and a certificate of need should be granted. This control function directly affects entry into the market and competition. *Because such decisions are tied to a state certificate of need law,* however, there is little question whether they are exempt from antitrust laws." (Emphasis added.) Cong. Rec. H. 11962 (Oct. 10, 1978).

The omitted language is crucial for it succinctly indicates that the antitrust laws do not apply to certificate of need decisions made by the designated state agency because of the "state action doctrine," and not because of an implied repeal.[24] As important, the omitted portion is crucial for it emphasizes that an exemption for private parties' conduct was not articulated.

3. *The Court of Appeals Ignored Traditional Rules of Statutory Construction In Construing the Antitrust Laws*

In the Act Congress provided for a specific, limited immunity in 42 U.S.C. § 300l-l(b)(4)(A). That immunity was reviewed and extended by Congress in 1979. In neither the initial legislation nor the subsequent amendment did Congress create a specific exemption from the antitrust laws for private parties. Instead, immunity was limited to the payment of damages and to individuals who were members or employees

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[24] It is important to distinguish, as did the Court of Appeals (682 F.2d, at 1054), the implied repeal doctrine from the state action exemption. Where conduct engaged in by private persons is illegal, the same conduct undertaken by state officials pursuant to an express legislative mandate will not be held to violate the antitrust laws. *Parker v. Brown,* 317 U.S. 341 (1943). Even "state action" immunity, however, will only be found were the challenged restraint is "one clearly articulated and affirmatively expressed as state policy" and the policy is actively supervised by the state itself. *California Retail Liquors Dealers Association v. Midcal Aluminum, Inc.,* 445 U.S. 97 (1980).

of an HSA where the conduct in question was "required of, or authorized to be undertaken by, *the* [*HSA*]."[25] (Emphasis added).

In spite of the requirement that in construing statutory provisions all the words and provisions of a statute "are intended to have meaning in order to be given effect" (*Wilderness Society v. Morton,* 479 F.2d 842, [D.C. Cir.] *cert. denied* 411 U.S. 917 [1973]), the Court of Appeals failed to consider the effect of the immunity provision. If Congress had intended to create an immunity from the antitrust laws for private parties, it could have, either in the original enactment or when it was subsequently amended. In fact, it chose not to do so.

The Court of Appeals also ignored the doctrine of *expressio unius est exclusio ulterius* which has explicitly been used by this Court in interpeting exemptions granted under the antitrust laws. For example, in *United States v. Borden Co.,* 308 U.S. 188, 201 (1939) this Court found that the explicit immunity provisions contained in the Agricultural Marketing Agreement Act defined the extent Congress intended that act should operate to render the Sherman Act inapplicable, holding

> "If Congress had desired to grant any further immunity, Congress would have done so."

Similarly, this Court in construing the Shipping Act, which contains an explicit provision exempting certain acts from antitrust scrutiny, held that conduct not covered by these explicit provisions could not be exempted. *Carnation Company v. Pacific Westbound Conf., supra,* 383 U.S., at 216-217.

The conclusion in this matter is unambiguous. Congress specifically provided immunity from damages for members or employees of a health systems agency in the performance of their duties. No other immunity was enacted or discussed. It must be inferred that Congress considered the question of creating immunity to make the Act function and determined that immunity was only to be available to the extent ultimately expressed. That expression does not extend to the conduct of third parties such as respondents.

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[25] *See* fn. 7 *supra.*

IV. CONCLUSION

The decision by the Eighth Circuit Court of Appeals exempts private anticompetitive conduct in the health care industry from the scrutiny of the antitrust laws. That conduct was not authorized or approved, nor subject to supervision or review by any federal or state agency. Yet, its potential anticompetitive effects have been placed beyond review as the result of two erroneous conclusions: (1) that there is a "plain repugnancy" between the National Health Planning and Resources Development Act and the antitrust laws; and (2) that Congress intended that private health planning activities be exempt from antitrust scrutiny.

This Court has determined, however, that such private conduct, wholly voluntary in nature, because of its potential pernicious anticompetitive effects must be subject to antitrust scrutiny. For this reason, the decision of the Court of Appeals for the Eighth Circuit must be reversed and the cause remanded for a trial on the merits.

Respectfully submitted,

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No. 80-802

In the Supreme Court of the United States

OCTOBER TERM, 1980

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER, PETITIONER

v.

BLUE CROSS OF KANSAS CITY AND BLUE CROSS ASSOCIATION

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether the National Health Planning and Resources Development Act of 1974 creates by implication an antitrust exemption for the voluntary actions of private health care insurance providers, when those actions are neither required by nor essential to the effectuation of any statute or government program, are not regulated by any government agency, and are not encompassed within the exemption from antitrust liability expressly prescribed in the Act.

TABLE OF CONTENTS

	Page
Interest of the United States	1
Statement:	
Legislative background	2
The proceedings below	4
Summary of argument	7
Argument:	
An antitrust exemption should not be created by implication in this case because application of the Sherman Act to the private exclusionary conduct challenged in the complaint would not conflict with or frustrate the goals of the National Health Planning and Resources Development Act	10
A. Application of the Sherman Act to the exclusionary conduct challenged in this case would not conflict with NHPRDA	12
B. The court of appeals erred in imputing to Congress an intent to confer on private parties unsupervised power to engage in anticompetitive acts	22
C. The court of appeals erred in recognizing a broad implied repeal of the antitrust laws in the face of statutory language conferring a narrow and carefully circumscribed antitrust exemption	25
Conclusion	28

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PREVIOUS PAGE WAS BLANK

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42 U.S.C. (Supp. III) 300*l*-1(b)(3)(C) 16
42 U.S.C. (Supp. III) 300*l*-1(b)(4) 9, 25, 26
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42 U.S.C. (Supp. III) 300*l*-2(b)(2) 16
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42 U.S.C. 300n-1(a) 9, 15, 24
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Statutes (Continued): Page

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In the Supreme Court of the United States

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

INTEREST OF THE UNITED STATES

The United States has an interest in assuring that the National Health Planning and Resources Development Act of 1974, 42 U.S.C. (& Supp. III) 300k *et seq.*, is interpreted and administered in a manner that promotes the congressional health planning policies embodied therein. The United States also has primary responsibility for enforcing the federal antitrust laws. It therefore has an interest in assuring that exemptions from the antitrust laws are not implied unless congressional intent to create such exemptions is clear. To the extent that an antitrust exemption must be implied to avoid frustrating the congressional purpose underlying the National Health Planning and Resources Development Act, the United States has an interest in assuring that the exemption is not broader than necessary and that the policies of both statutes are effectuated to the greatest extent possible.

The United States also has a more specific interest in the issue presented in this case. The extent, if any, to which an antitrust exemption should be recognized under the National Health Planning and Resources Development Act not only will affect law enforcement decisions concerning anticompetitive conduct by insurance providers, hospitals, and others in the health services field, but also will affect the advice given by government agencies to private parties seeking to effectuate the policies of the Health Planning Act while conforming their activities to the requirements of the antitrust laws.

STATEMENT

Legislative Background

1. Congress enacted the National Health Planning and Resources Development Act of 1974 ("NHPRDA") for the purpose of developing a national health policy to be carried out through a system of state and areawide health programs. The statute's ultimate aim was to make quality health care available to all citizens at a reasonable cost. 42 U.S.C. 300k; S. Rep. No. 93-1285, 93d Cong., 2d Sess. 1, 40 (1974).

The new statute, which revised and unified various prior programs,[1] called for a three-tiered regulatory scheme to coordinate federal, state and local efforts. At the federal level, the Secretary of Health, Education, and Welfare (now Health and Human Services) was required to issue guidelines and goals for a national health planning policy on the recommendation of a new permanent body within HEW, the National Advisory Council on Health Planning and Development. 42 U.S.C. 300k-1, 300k-3.

At the local level, Congress created a system of health systems agencies ("HSAs") to serve geographic areas selected by the state governors with the Secretary's ap-

[1] The legislative programs that preceded NHPRDA are reviewed in some detail at S. Rep. No. 93-1285, *supra*, at 4-39.

proval. 42 U.S.C. 300*l*. Congress prescribed that HSA governing bodies must include publicly elected officials as well as consumers and providers of health care services, with a majority representing consumer interests. 42 U.S.C. 300*l*-1. HSAs may be non-profit private corporations, public regional planning bodies, or single units of local government. 42 U.S.C. 300*l*-1(b).[2] They are charged with areawide health planning and development to improve the health of their residents, assure quality health care, restrain increasing costs of such care, and prevent unnecessary duplication of health services. 42 U.S.C. 300*l*-2(a). With the assistance (to the extent practicable) of interested persons in the health service area, HSAs are required to assess their area's health resources, develop long-range health systems plans ("HSPs"), develop short-term implementation plans, review proposed and existing health projects, services, and facilities, and make recommendations to the state agency regarding the need for new services and the appropriateness of existing services. 42 U.S.C. 300*l*-2(b), (c), (f), (g). They also are authorized to approve or disapprove the use of federal funds for specific types of area health projects. 42 U.S.C. 300*l*-2(e).

At the state level, the Act provides for the designation by each governor of a State Health Planning and Development Agency ("State Agency") to develop state health plans on the advice and recommendation of Statewide Health Coordinating Councils ("SHCCs"). The State Agencies are empowered to review the continuing need for existing institutional health services and facilities and to review applications for federal funding of state health programs. 42 U.S.C. 300m-2(a), 300m-3(a). In discharging its planning and review functions, the State Agency is to consider the recommendations of the HSAs. 42 U.S.C. 300m-2(a)(4)-(6).

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[2] More than 200 approved HSAs are now in existence. Approximately 90% of them are non-profit private corporations. S. Rep. No. 96-96, 96th Cong., 1st Sess. 35 (1979).

As one of the conditions for federal funding, the Act requires that a State Agency establish a "certificate of need" program that is satisfactory to the Secretary. 42 U.S.C. 300m-2(a)(4)(B). Under the certificate of need program, HSAs are required to "review and make recommendations" to the State Agency regarding "the need for new institutional health services proposed to be offered or developed in [its] health service area * * *." 42 U.S.C. 300*l*-2(f). The State Agency, in turn, must make determinations as to the need for proposed new institutional health services "[a]fter consideration of recommendations submitted by health systems agencies * * *." 42 U.S.C. 300m-2(a)(5).

2. Congress amended NHPRDA in 1979. See S. Rep. No. 96-96, 96th Cong., 1st Sess. 6 (1979). Having reviewed the strengths and weaknesses of the 1974 legislation, Congress sought to remedy some of the Act's deficiencies. It declared, however, that its aim was to strengthen, not disrupt, the statutory program initiated in 1974. S. Rep. No. 96-96, *supra*, at 8-9. To this end, the 1979 amendments added new controls to planning and certificate of need review, extended certificate of need review to major acquisitions of medical equipment, assured more effective consumer participation in HSAs, conferred damage liability protection on HSAs and SHCC members, and directed that special consideration be given throughout the planning process to the importance of maintaining and improving competition in the health industry. See 42 U.S.C. (Supp. III) 300k-2(a)(17) and (b); 300*l*-1(b)(4)(A)(i); 300m-2(a)(4)(B); 300m-3(d); 300n-1. See also S. Rep. No. 96-96, *supra*, at 2-3, 53, 56-63, 77-80, 85.

The Proceedings Below

Petitioner brought this action against respondents Blue Cross of Kansas City and Blue Cross Association under Sections 1 and 2 of the Sherman Act, 15 U.S.C. 1 and 2, alleging that Blue Cross of Kansas City wrongfully had

refused to accept petitioner as a participating member provider in its health insurance plan. The complaint further alleged that this refusal occurred because petitioner had not obtained a finding of need from Mid-America Health Services Agency ("MAHSA"), a party alleged to be a co-conspirator in the antitrust violation but not named as a defendant in the complaint.[3]

Respondent Blue Cross of Kansas City ("Blue Cross") is a private health services corporation that sells prepaid health care plans to the public in Missouri and Kansas and contracts with health care providers to administer its plans (Pet. App. 20a). Respondent Blue Cross Association is the national parent association of Blue Cross. MAHSA is a private not-for-profit Missouri corporation established as a health systems agency pursuant to NHPRDA.

Petitioner National Gerimedical is a general acute care hospital located in Missouri. Before opening in 1978, it sought to enter into a participating hospital agreement with Blue Cross under which National Gerimedical would receive 100% reimbursement directly from Blue Cross for all services provided to Blue Cross policyholders. Without that contract, National Gerimedical would have to bill Blue Cross subscribers who then would be reimbursed by Blue Cross for only 80% of the hospital bill (Pet. App. 20a).[4]

Although not required to do so by either federal or state law, Blue Cross conditioned its grant of participating membership to a new hospital on the hospital's receipt of a finding from the local HSA (in this case MAHSA) that a new hospital was required to serve a "clearly evident need" for health care services in the

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[3] Petitioner also alleged violations of Missouri's antitrust laws (Pet. App. 18a).

[4] All acute general care hospitals in the Blue Cross service area, except petitioner, have contracted with Blue Cross and are thus "participating" hospitals (Pet. App. 20a).

area (Pet. App. 6a-7a, 21a).[5] Petitioner, however, neither sought nor received MAHSA approval since MAHSA previously had announced that it would disapprove the addition of any new acute care hospital beds (*id.* at 7a, 21a). Consequently, Blue Cross denied National Gerimedical a participating member contract because it had not obtained a finding of "clearly evident need" from MAHSA (*id.* at 20a-21a).

Following Blue Cross's denial of National Gerimedical's application, National Gerimedical filed this action in the United States District Court for the Western District of Missouri. Respondents moved to dismiss the complaint on the ground, *inter alia*, that NHPRDA implicitly repealed the antitrust laws to the extent that the challenged action was undertaken to effectuate the purposes of the Act.[6]

The district court granted summary judgment in respondents' favor and dismissed the complaint (Pet. App. 19a, 44a). It found a clear repugnancy between NHPRDA and the antitrust laws, and concluded that Congress intended that private actions, taken pursuant to NHPRDA and "clearly within [its] scope," be exempt from application of the antitrust laws (*id.* at 37a). In finding a conflict between NHPRDA and the antitrust laws, the court did not measure the challenged conduct against the requirements of NHPRDA. Instead, it concluded that "the entire concept of the * * * Act" revealed that Congress intended to create a blanket antitrust exemption (*id.* at 32a). It added that "the antitrust laws were not intended to apply to members of the health care

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[5] During the relevant time period, the state of Missouri had not authorized a state agency to render "certificate of need" determinations and no certificate of need program was in effect (Pet. App. 7a).

[6] Respondents also claimed that their conduct was exempt from the antitrust laws under the McCarran-Ferguson Act, 15 U.S.C. 1011 *et seq.*, and that the prepaid medical plans at issue did not constitute a part of "trade or commerce" within the meaning of

industry clearly acting within the scope of the Act" (*id.* at 33a).[7]

The court of appeals affirmed (Pet. App. 1a-15a). It agreed with the district court that a "clear repugnancy between the Act and the antitrust laws" exists, since "the Act and regulatory scheme clearly call for the action which has now become the basis of an antitrust claim" (*id.* at 11a). The court relied in particular on 42 U.S.C. (Supp. III) 300*l*-2(a)(4) and 300*l*-2(c)(1), which describe as one of the statute's goals the prevention of "unnecessary duplication of health resources," and further provide that each HSA " '*shall* seek, to the extent practicable, to implement its [health plans] with the assistance of individuals and public and private entities in its health service area' " (Pet. App. 3a-9a). The court of appeals also adopted *in toto* the district court's finding that the legislative history revealed congressional intent "to immunize this type of voluntary action from the antitrust laws" (Pet. App. 11a-15a).

SUMMARY OF ARGUMENT

The court of appeals erred in imputing to Congress an intent to immunize from the antitrust laws private conduct which is neither required by nor essential to the effectuation of any statute, which is not regulated by any government body, and which is not encompassed within the express antitrust exemption prescribed by Congress in NHPRDA. In bestowing a broad implied immunity, the court of appeals not only frustrated the policy of open competition embodied in the Sherman Act, but also disregarded the provisions of NHPRDA that pre-

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the Sherman Act (Pet. App. 18a, 38a-39a). Those claims were rejected by both courts below (*id.* at 15a, 22a-27a, 38a-44a), and are not before this Court.

[7] The district court stated that the legislative history showed that "any" attempts to reduce costs and duplication of services by health care providers "were to be welcomed." Pet. App. 34a; see also Pet. App. 12a.

scribe a carefully circumscribed regulatory scheme for barring new hospital entry.

1. It is well settled that an exemption from the antitrust laws may be judicially inferred only when there is a plain repugnancy between the antitrust laws and a subsequently enacted statute on which the implied exemption is based. *FMC* v. *Seatrain Lines, Inc.*, 411 U.S. 726, 733 (1973). No such repugnancy exists in this case. There is no provision in NHPRDA that required Blue Cross to take steps to create economic barriers to petitioner's entry into the hospital market—the exclusionary conduct challenged in the complaint. And there is no reason to believe that scrutiny of Blue Cross's conduct under the antitrust laws will frustrate any goal of NHPRDA.

NHPRDA places basic planning and advisory functions in the hands of local Health Systems Agencies. Regulatory determinations concerning new entry, however, are entrusted to State Agencies. Local Health Systems Agencies (such as MAHSA) are expected to advise state agencies, but they have no authority to preclude new entry into the health care market by parties such as National Gerimedical. Moreover, NHPRDA delegates no authority of any kind to private parties such as Blue Cross to raise barriers to new hospital entry. In these circumstances, prohibition of private exclusionary conduct in violation of the antitrust laws would reinforce, rather than frustrate, the goals of NHPRDA, since it would reserve the power to allow or deny new entry to State Agencies as envisioned by Congress.

2. Blue Cross also has failed to sustain its weighty burden to establish that Congress intended to displace normal competitive forces with private economic restraints. The terms of NHPRDA evidence no such intent. And the absence of any regulatory supervision of the conduct challenged in this case gives rise to a presumption that Congress did *not* intend to place such conduct beyond the range of antitrust scrutiny. See *Silver* v. *New York Stock Exchange*, 373 U.S. 341 (1963); *Otter Tail Power Co.* v. *United States*, 410 U.S. 366, 374 (1973).

The structure of NHPRDA reinforces this presumption. To the extent that State Agencies are entrusted with decisions that could result in economic penalties against a provider, or displace free competition with governmental regulation, the Act prescribes procedures that guarantee notice, opportunity to comment, a fair hearing, and administrative and judicial review. 42 U.S.C. 300n-1(a), (& Supp. III) 300n-1(b). Thus, Congress has demonstrated substantial concern for the fairness of procedures leading to decisions to exclude new entrants such as National Gerimedical. By conferring antitrust immunity on private parties that are not subject to administrative or judicial review, the court of appeals has undermined the sensitive balance fashioned by Congress.

3. Finally, the court of appeals' recognition of a broad implied antitrust immunity cannot be squared with Congress' considered decision to grant only a limited express immunity under NHPRDA. The legislative history shows that arguments in favor of broader antitrust immunity to cover private parties, agents, and consultants of HSAs were made before Congress, but Congress chose to limit liability solely to damage claims against HSAs and members and employees of HSAs and SHCCs. 42 U.S.C. (& Supp. III) 300*l*-1(b)(4), 300m-3(d). In view of this clear expression of legislative intent, and the absence of any evidence that the challenged conduct was necessary to effectuate the statutory scheme, the court of appeals erred in granting an implied immunity that transcends the narrow limitations prescribed by statute. *United States* v. *Borden Co.*, 308 U.S. 188, 201 (1939).

ARGUMENT

AN ANTITRUST EXEMPTION SHOULD NOT BE CREATED BY IMPLICATION IN THIS CASE BECAUSE APPLICATION OF THE SHERMAN ACT TO THE PRIVATE EXCLUSIONARY CONDUCT CHALLENGED IN THE COMPLAINT WOULD NOT CONFLICT WITH OR FRUSTRATE THE GOALS OF THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT

In a long line of cases, this Court has repeated the admonition that implied exemptions from the antitrust laws are disfavored. As noted in *Carnation Co.* v. *Pacific Westbound Conference*, 383 U.S. 213, 218 (1966): "We have long recognized that the antitrust laws represent a fundamental national economic policy and have therefore concluded that we cannot lightly assume that the enactment of a special regulatory scheme for particular aspects of an industry was intended to render the more general provisions of the antitrust laws wholly inapplicable to that industry." Thus, "[r]epeal of the antitrust laws by implication is not favored and not casually to be allowed. Only where there is a 'plain repugnancy between the antitrust and regulatory provisions' will repeal be implied." *Gordon* v. *New York Stock Exchange*, 422 U.S. 659, 682 (1975). See *United States* v. *National Ass'n of Securities Dealers, Inc.*, 422 U.S. 694, 719-720 (1975); *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, 787 (1975); *FMC* v. *Seatrain Lines, Inc.*, 411 U.S. 726, 733 (1973); *Otter Tail Power Co.* v. *United States*, 410 U.S. 366, 372 (1973); *United States* v. *Philadelphia National Bank*, 374 U.S. 321, 350-351 (1963).

Repugnancy may be found to exist only when application of the antitrust laws to the practice at issue would frustrate the congressional intent evidenced in a later-enacted regulatory statute. *Gordon* v. *New York Stock Exchange*, *supra*, 422 U.S. at 689-690. "Repeal is to be

regarded as implied only if necessary to make the [subsequent statute] work, and even then only to the minimum extent necessary." *Silver* v. *New York Stock Exchange*, 373 U.S. 341, 357 (1963); accord, *United States* v. *Borden Co.*, 308 U.S. 188, 198, 199 (1939) ("the rule is to give effect to both [statutes] if possible" and "the old law is repealed by implication only *pro tanto* to the extent of the repugnancy"). Examination of the court of appeals' decision reveals that the conduct in question in this case was not measured against the foregoing standards and that, when those standards are applied to the challenged conduct, there exists no plain repugnancy between NHPRDA and the Sherman Act.[8]

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[8] In asserting that respondents' conduct is not immunized from antitrust scrutiny, we do not imply that the conduct violates the Sherman Act. This Court is not faced here with a question of violation, but of immunity. Practices can be non-immune and still be entirely lawful. *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 210 n.5 (1979). Following a trial or summary judgment hearing addressed to the merits, respondents' conduct may be found lawful for several reasons. Blue Cross may not have monopoly power in the insurance market in which it operates. Even if it does, its refusal to deal may not have been premised on a desire to abuse its monopoly power either in the insurance market or to gain an advantage in the hospital services market. See *United States* v. *Colgate Co.*, 250 U.S. 300, 307 (1919); cf. *Otter Tail Power Co.* v. *United States*, *supra*, 410 U.S. at 377-378.

The correct resolution of a charge of abuse of monopoly power turns on the economic context in which the conduct occurs. In this case, Blue Cross acts on behalf of its insureds as a purchaser of hospital services from various suppliers, *i.e.*, hospitals. It is difficult to imagine why an enterprise, whether or not a monopolist, would prefer to have fewer rather than more suppliers unless it perceived a likelihood of excessive investment at the supply level which would redound to its detriment in the form of higher costs. Under normal competitive circumstances, additions to capacity or new entry at the supply level would have a tendency to lower prices, whatever the effect on average supplier costs. Thus, when demand is elastic, *i.e.*, sensitive to price, and competitive services are viewed as substitutable, suppliers who overinvest in capacity will be forced to absorb their higher average costs on pain of losing customers. However, where overall demand is inelastic and the

A. Application Of The Sherman Act To The Exclusionary Conduct Challenged In This Case Would Not Conflict With NHPRDA

There can be no repugnancy between the Sherman Act and NHPRDA within the meaning of the decisions described above because NHPRDA neither requires the conduct challenged under the antitrust laws in this case nor depends on that conduct to achieve its objectives. To the contrary, as we demonstrate below, the procedures and safeguards prescribed by Congress in NHPRDA to control new entry are undermined by the court of appeals' immunization of unsupervised private efforts to erect entry barriers in the health care field.

1. The court of appeals conferred antitrust immunity on the acts of private parties seeking to preclude a new hospital from effectively competing to provide health care services. Neither the language nor the legislative history of NHPRDA, however, indicates a congressional intent to *require* such exclusionary private conduct. Blue Cross cannot point to any statutory language that compelled its

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service or product is not viewed as substitutable, this competitive market discipline is diluted and the additional costs of excess investment may be passed on to purchasers. To the extent that the existence of health insurance has reduced significantly the general demand elasticity for hospital services, and individual hospitals are not viewed by patients as substitutable since the choice is often determined by physician affiliation rather than patient choice, the costs of overinvestment in hospital capacity can be passed on to the purchasers of hospital services. In such circumstances, an insurance company which unilaterally sought to discourage excess investment in new hospital capacity in order to reduce costs to its insureds would not, by such action alone, be evidencing any anticompetitive intent. Its purpose, moreover, would be consistent with the congressional desire to avoid unnecessary duplication.

Similarly, petitioner's restraint of trade claim may fail for lack of an agreement (or "concerted conduct") between Blue Cross and any other party. Of course, if petitioner proves that Blue Cross's refusal to offer it participating membership status is the result of an unlawful agreement between Blue Cross and some or all of the other hospitals in the area, it would be entitled to relief under the Sherman Act.

conduct. The only relevant statutory reference to private conduct appears in 42 U.S.C. 300*l*-2(c)(1), which provides:

> The [health systems] agency shall seek, to the extent practicable, to implement its HSP [health systems plan] and AIP [annual implementation plan] with the assistance of individuals and public and private entities in its health service area.

This legislative prompting of HSAs to cooperate with and seek the assistance of private parties hardly can be viewed as a clear directive to private providers to take independent action to "enforce" any exclusionary policy that an HSA espouses. The absence of any such statutory directive was not the product of inadvertence. Under the certificate of need program, the role of HSAs is purely advisory. Only State Agencies may deny new entry on the ground that such entry would produce unnecessary duplication of services (see pages 13-14, 23-25, *infra*). Since Congress withheld from HSAs the power to preclude new entry, it would be anomalous to impute to it an intent to permit—let alone require—private parties to preclude new entry under the guise of implementing HSA recommendations.

2. There is, moreover, no basis for inferring that subjection of Blue Cross's conduct to antitrust scrutiny would frustrate any of NHPRDA's goals. NHPRDA contemplates a carefully interrelated system of federal, state, and local agencies whose function is to assure adequate health care to all Americans, while eliminating unnecessary costs. The state certificate of need programs, which require state approval before new construction or expansion of institutional services can take place, play a central role in this scheme (see S. Rep. No. 96-96, *supra*, at 5). Within the certificate of need framework, the HSAs play an essential advisory role, but have no regulatory powers. 42 U.S.C. 300*l*-2(f), (& Supp. III) 300*l*-2(g)-(h). All their recommendations on certificates of need are reviewed by the State Agency, which alone has

power to deny a request to provide more hospital beds. This separation of powers between the HSAs and State Agencies was deliberate. Congress recognized that (emphasis supplied):

> Although the keystone to the health planning effort envisioned in the proposed Committee legislation is the areawide health planning agency * * * the performance of regulatory functions [is] most appropriately carried out at the State level. *The [regulatory] function can appropriately be carried out only by an agency of State government.*

S. Rep. No. 93-1285, *supra*, at 52; *accord*, S. Rep. No. 96-96, *supra*, at 67.

Under NHPRDA, therefore, MAHSA had no power to deny a certificate of need with preclusive effect on new entrants. Only the state of Missouri could exercise that power, after reviewing MAHSA's recommendation. Since Congress denied HSAs the power to erect barriers to new hospital entry, denying such power to private parties who purport to enforce HSA recommendations would not frustrate the statutory scheme.

3. Instead of analyzing the overall statutory scheme described above, the court of appeals seized on isolated phrases in the statute to support the view that Blue Cross's conduct was "clearly call[ed] for" by NHPRDA (Pet. App. 11a).[9] The court placed principal reliance on 42 U.S.C. (Supp. III) 300*l*-2(a)(4), which calls on health systems agencies to formulate plans with a view toward preventing "unnecessary duplication of health resources" (Pet. App. 3a). The court also relied on 42 U.S.C. 300*l*-2(c)(1), which directs HSAs to "seek, to the extent practicable," to implement their health plans "with the assistance of individuals and public and private entities in [their] health service area."

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[9] The district court concluded, with less certainty, that Blue Cross's certificate of need requirement "*seems to be authorized* by the Act" (Pet. App. 32a; emphasis added).

The statutory goal of avoiding "unnecessary duplication," however, is only one of many goals to be considered in evaluating proposals and making plans. See 42 U.S.C. 300k, (& Supp. III) 300k-2 and 300*l*-2(a).[10] These goals, although important, are broadly stated and quite general. While such generality is acceptable, perhaps even unavoidable, when delegating authority to an administrative agency, it hardly reflects a congressional judgment that a broad category of voluntary private conduct must be immunized from the antitrust laws if the public interest in health care is to be fostered. The statutory desire to reduce "unnecessary" duplication, of course, is not self-defining. If all duplication were deemed undesirable, the adjective "unnecessary" would not have been included. Determining the point where duplication ceases to be desirable requires a careful balancing of sometimes conflicting values, *e.g.*, facilitating consumer choice versus limiting short term costs. Moreover, in those instances where Congress determined that it would serve the public interest to supplant competitive entry with a certificate of need program, it vested the responsibility to balance these values in responsible State Agencies, not in private parties. When new entry is denied by government authorities after balancing these various public interest values, the statute provides explicit procedural safeguards, including judicial review of administrative action. 42 U.S.C. 300n-1(a), (& Supp. III) 300n-1(b). The fact that Congress prescribed such pervasive procedural safeguards in the certificate of need program "refutes the argument that private controls of competition are necessary in the public interest and ought therefore to be immune from scrutiny under the antitrust laws." *United States* v. *Philadelphia National Bank*, 374 U.S. 321, 352 (1963).

Nor is there merit in the court of appeals' conclusion that the statutory mandate that HSAs "seek the assist-

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[10] 42 U.S.C. (& Supp. III) 300k-2(a) lists seventeen national health priorities.

ance" of private entities requires a displacement of the antitrust laws.[11] Congress plainly intended to encourage communication between the public and HSAs, but parties may consult with HSAs and give their views on health planning issues without abusing monopoly power or entering into unlawful agreements in restraint of trade, as alleged in the complaint in this case.[12]

4. While relying on the general statutory language discussed above, the court of appeals disregarded the only

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[11] To be sure, there are some activities that must, by implication, be immune from antitrust attack if HSAs and State Agencies are to exercise their authorized powers. Since the Act requires HSAs, in developing their plans, to seek the assistance of private parties, consultation with an HSA in the planning process would be protected. Similarly, there may be occasions in implementing health systems plans when an implied exemption might be necessary in order to effectuate the statutory scheme as required by Congress. But under the Act, the forum for developing a health systems plan is an open one. The HSA is required to conduct a public hearing on its proposed health plan, and to offer the opportunity for oral and written comment. The final plan must be consistent with federal guidelines or the HSA must explain why it is not. 42 U.S.C. (Supp. III) 300*l*-2(b)(2). Thus, HSA decisionmaking is public and open, and carefully supervised.

[12] Congress expressed concern over abuses by health providers in the planning process. Thus, while recognizing that area health service providers (including "insurers"—42 U.S.C. 300n(3)(B)(iv)) should participate in health planning, Congress noted that, because of the potential for conflicts of interest with respect to HSA recommendations, "their influence on the health planning process must be appropriately limited." S. Rep. No. 93-1285, *supra*, at 46.

Congress also expressed concern about provider domination of planning agency decisions under prior programs, and sought to curtail it, in part by limiting provider representation on HSA governing boards. S. Rep. No. 96-96, *supra*, at 4-5; 42 U.S.C. 300*l*-1(b)(3)(C). To further check provider abuse of the planning process, the 1979 amendments added conflict of interest provisions to prevent providers serving on HSA boards or SHCCs from voting on matters in which they have a financial interest. Pub. L. No. 96-79, 93 Stat. 606; 42 U.S.C. (Supp. III) 300m-3(e).

statutory language that specifically refers to competition. 42 U.S.C. (Supp. III) 300k-2(a)(17), prescribes as a national health priority the "strengthening of competitive forces in the health services industry" when competition can serve the public interest. Indeed, the 1979 Senate Committee Report viewed the promotion of competition in the health services industry to be as important as encouraging cost containment.[13] In furtherance of the goal of increased competition, 42 U.S.C. (Supp. III) 300k-2(b)(1)-(3) calls for promotion of competition when it can serve the public interest, and HSAs are directed to chart their course with a view to "preserving and improving, in accordance with section 300k-2(b) of this title, competition in the health service area." 42 U.S.C. (Supp. III) 300*l*-2(a)(5).[14] The court of appeals' failure to

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[13] See S. Rep. No. 96-96, *supra*, at 85 (emphasis supplied):

> The Committee realizes that since initiation of the Act, the orientation of the planning process has become increasingly centralized, threatening to leave out competition altogether. With these provisions, the Committee introduces into the health planning law the recognition *that planning agencies at all levels have as important a responsibility to promote competition among health care providers as the obligation to encourage cost containment, facility closure or shared services.* The experience with other public regulatory authorities has been one of creating industry cartels which emphasize market stability rather than innovation and consumer preference. The Committee intends to protect against such tendencies in health sector regulation.

[14] Sections 300k-2(a)(17), 300k-2(b)(1)-(3), and 300*l*-2(a)(5) were added to NHPRDA in 1979. The legislative history shows that the endorsement of competition in 1979 was not a change in underlying statutory design. See S. Rep. No. 96-96, *supra*, at 5, 8-9, 50, 52 (noting that these amendments are designed to strengthen the "basic character and structure of the health planning program * * *"). There is no indication that the later Congress believed that its predecessor had rejected competition and the antitrust laws in the health care field.

Indeed, Jacob Getson, a member of the Board of Directors of the American Health Planning Association, the national association for

recognize the important role that competition plays under NHPRDA, as evidenced by these provisions, undoubtedly contributed to its misreading of the legislative intent.[15]

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state and local health planning agencies, testified during hearings on the 1979 amendments that

> health planning agencies can and should use their Health Systems Plan, Annual Implementation Plans, and related implementation activities to promote and encourage the marketplace forces and fair competition in health care in these communities. We believe that this can be done under the present law without amendment. It would be desirable to provide additional clarification in the report to accompany the bill that such activities are desirable when they serve to advance such purposes as cost moderation, quality assurance, accessibility and responsiveness to consumer preference.

Hearings on H.R. 3041 and H.R. 3167 Before the House Subcomm. on Health and the Environment of the Comm. on Interstate and Foreign Commerce, 96th Cong., 1st Sess. 171, 177 (1979) (hereinafter referred to as "*Hearings*").

[15] The courts below pointed to congressional concern over increasing hospital costs and improper utilization of existing facilities (Pet. App. 11a-13a, 33a-34a), and Committee Reports calling for prevention of unnecessary duplication of resources and implementation of health plans with assistance from the private sector (*ibid.*). Those congressional materials, however, simply restate the provisions of the bill that ultimately were enacted. They add no different gloss to the statutory language.

Both lower courts placed considerable reliance on remarks of Rep. Rogers in debates preceding the 1979 amendments (Pet. App. 14a-15a, 34a-35a). That reliance is misplaced. First, the remarks were made in debates on H.R. 11488, 95th Cong., 2d Sess. (1978), a health planning amendments bill that did not pass the 95th Congress, and which contained no reference to competition at all, as did its successor—S.544, 96th Cong., 1st Sess. § 154 (1979). Thus, even if directed at the type of case presented here, Rep. Rogers' individual views do not bear the weight given them by the lower courts in light of the fact that the 96th Congress enacted amendments specifically endorsing competition and rejected suggestions that comprehensive immunity from the antitrust laws be extended to private parties acting in cooperation with health planning bodies (see pages 25-27, *infra*).

Nor are Rep. Rogers' remarks evidence of Congress's original intent in enacting NHPRDA for, as this Court frequently has held,

5. In its Brief in Opposition to the Petition for a Writ of Certiorari (Br. in Opp. 14-16), respondent Blue Cross Association distinguishes 42 U.S.C. (Supp. III) 300k-2(b)(2) from 300k-2(b)(3) in order to advance the argument that Congress intended the 1979 amendments to foreclose competition for "inpatient" health services while promoting competition with respect to "outpatient" services.[16] This, however, is a misreading of the statute, and in any event does not advance BCA's immunity argument regarding private parties. While Congress recognized that free competition in certain segments of the health services

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opinions of individual legislators voiced after passage of legislation should be accorded little weight. *United States* v. *Philadelphia National Bank, supra*, 374 U.S. at 348-349; *United States* v. *United Mine Workers*, 330 U.S. 258, 282 (1947). Rep. Rogers' remarks fail to indicate a clear Congressional intent to create a broad antitrust exemption for yet another reason: they were made to counter statements by others that NHPRDA did *not* bestow antitrust immunity sufficient to exempt all cooperative efforts of hospitals and HSAs. 124 Cong. Rec. H11962 (daily ed. Oct. 10, 1978). Finally, Rep. Rogers did not address the situation presented here—the action of Blue Cross in granting and withholding its own participating member contracts. Rather, he was addressing a situation in which private parties were merely participating in HSA activities, as contemplated by the NHPRDA. See note 11, *supra*.

[16] 42 U.S.C. (Supp. III) 300k-2(b)(2) and 300k-2(b)(3) provide as follows:

> For health services, such as inpatient health services and other institutional health services, for which competition does not or will not appropriately allocate supply consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the exercise of their functions under this subchapter take actions * * * to allocate the supply of such services.
>
> For the health services for which competition appropriately allocates supply consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the performance of their functions under this subchapter give priority * * * to actions which would strengthen the effect of competition on the supply of such services.

market, such as institutional inpatient services, might not always efficiently allocate supply, it did not foreclose competition in that institutional setting if competition is in fact found to be working.[17] Congress merely provided that, while competition generally should receive priority in health planning, planning bodies may displace competition and allocate supply themselves in cases where free market forces do not allocate supply in an efficient manner. Moreover, if competitive forces are not working effectively, it is State Agencies, not private parties, which possess statutory authority to allocate supply through grants and denials of certificates of need. See 125 Cong. Rec. H8234 (daily ed. Sept. 20, 1979) (remarks of Rep. Staggers).

The fact that Congress recognized the need to impose entry restrictions on new hospital construction—in the form of a certificate of need program—does not by itself evince an intent to displace the antitrust laws.[18] The

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[17] The Senate Committee Report stated:

> Despite the fact that the health care industry has not to date responded to classic marketplace forces, the committee believes that the planning process—at the Federal, State, and local level—should encourage competitive forces in the health services industry wherever competition and consumer choice can constructively serve to advance the purposes of quality assurance and cost effectiveness.

S. Rep. No. 96-96, *supra*, at 53.

[18] It is well-settled that "[a]ctivities which come under the jurisdiction of a regulatory agency nevertheless may be subject to scrutiny under the antitrust laws." *Otter Tail Power Co.* v. *United States*, *supra*, 410 U.S. at 372. Accord, *Ricci* v. *Chicago Mercantile Exchange*, 409 U.S. 289, 302 n.13 (1973) (Commodity Exchange Act regulation of membership on the Exchange does not "confer general antitrust immunity on the Exchange and its members with respect to that area of conduct within the adjudicative or rulemaking authority of the Commission or the Secretary"); *Maryland & Virginia Milk Producers Ass'n* v. *United States*, 362 U.S. 458, 466-467 (1960) (regulation of a dairy cooperative by the Secretary of Agriculture under the Capper-Volstead Act does not immunize the cooperative against all monopolization and conspiracy charges).

Communications Act of 1934, 47 U.S.C. 309, similarly limits entry into broadcasting, but that factor is not sufficient to establish a congressional intent to displace the antitrust laws. *United States* v. *R.C.A.*, 358 U.S. 334 (1959). In industries where Congress has chosen both to limit entry and displace the antitrust laws, it has conferred express exemption power on the agency. See, *e.g.*, 49 U.S.C. 1384 (Federal Aviation Act); 49 U.S.C. (Supp. III) 10706 (Interstate Commerce Act). Absent express exemption authority, even formal agency approval of conduct not necessary to effectuate the statutory scheme does not immunize private anticompetitive conduct. See, *e.g.*, *California* v. *FPC*, 369 U.S. 482, 486, 490 (1962) (Federal Power Commission approval under the Natural Gas Act of certain acquisitions does not displace the Clayton Act); *United States* v. *R.C.A.*, *supra*, 358 U.S. at 346, 350-351 (Federal Communications Commission approval of an exchange of television stations does not immunize the transaction from antitrust challenge); *United States* v. *Philadelphia National Bank*, *supra*, 374 U.S. at 350-355 (approval of a bank merger by banking regulators does not foreclose antitrust scrutiny).

Since official approval is not sufficient by itself to confer an antitrust exemption on what essentially is voluntary private conduct, it follows *a fortiori* that the antitrust laws are not rendered inapplicable in this case simply because Blue Cross may have believed that its alleged exclusionary practices were in furtherance of a general regulatory purpose such as avoiding unnecessary expenditures or duplication of services. See *United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. 150, 227-228 (1940) ("The fact that the [defendants'] buying programs may have been consistent with the general objectives and ends sought to be obtained under the National Industrial Recovery Act is likewise irrelevant to the legality under the Sherman Act of [their] activities * * *").

B. The Court Of Appeals Erred In Imputing To Congress An Intent To Confer On Private Parties Unsupervised Power To Engage In Anticompetitive Acts

In seeking to impute to Congress an unexpressed intent to displace the fundamental national economic policy embodied in the antitrust laws, respondents bear a heavy burden. Respondents' burden is particularly heavy in this case since their argument attributes to Congress an intent to commit unsupervised public power to private hands, contrary to the traditional allocation of economic regulatory power in our free enterprise system.

In *Silver* v. *New York Stock Exchange*, *supra*, 373 U.S. at 357-367, this Court considered the activities of a stock exchange that Congress had authorized to engage in some measure of private self-regulation. The Court concluded that the failure of Congress to provide regulatory supervision over the specific conduct challenged under the antitrust laws established that there was not a sufficient conflict between the regulatory scheme and the antitrust laws to support an implied exemption. The Court's decision reflected the principle that private parties may not arrogate to themselves authority to impose significant restraints on competition, even if they purport to serve the public interest. Such authority is public in nature: it is not lightly entrusted to private hands. *Fashion Originators' Guild* v. *FTC*, 312 U.S. 457, 465 (1941) ("the combination is in reality an extra-governmental agency, which prescribes rules for the regulation and restraint of interstate commerce, and provides extra-judicial tribunals for determination and punishment of violations, and thus 'trenches upon the power of the national legislature and violates the statute' ") ; accord, *Associated Press* v. *United States*, 326 U.S. 1, 19 (1945). Private parties seeking to exercise such powers must establish clearly that Congress intended such an exceptional result, and even then procedural fairness must be afforded to persons who may be ad-

versely affected.[19] Neither the requisite congressional intent to confer private exclusionary power, nor safeguards against its abuse, are found in NHPRDA.

To the contrary, as we have noted above, NHPRDA places the process of health planning and implementation in the hands of HSAs and governmental bodies. In carrying out their duties under a certificate of need program, HSAs and State Agencies are required by statute to follow established guidelines and employ prescribed procedures, subject at every level to administrative oversight or judicial review. Congress contemplated that private parties, such as Blue Cross, would be participants in a system of voluntary cooperation, where motivations "are governed in the first instance by business judgment and not regulatory coercion * * *." *Otter Tail Power Co.* v. *United States, supra*, 410 U.S. at 374. As to these private parties, "courts must be hesitant to conclude that Congress intended to override the fundamental national policies embodied in the antitrust laws." *Ibid.*

This caveat applies with particular force here. NHPRDA does not give even HSAs or State Agencies unfettered authority to bar new entry into the health services field. HSA recommendations to refuse certificates of need are advisory only. 42 U.S.C. 300*l*-2(f). They must be referred to the State Agency for a final decision. 42 U.S.C. (& Supp. III) 300m-2(a)(4) and 300m-2(a)(5). Moreover, all certificate of need decisions must be consistent with a State Health Plan (42 U.S.C. (Supp. III) 300m-6(a)(5)) and state certificate of need programs must be consistent with standards adopted by the Secretary of HHS. *Ibid.* At both the HSA and State Agency levels, there are opportunities for notice and com-

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[19] *Silver* v. *New York Stock Exchange, supra*, 373 U.S. at 361-364; L. Sullivan, *Antitrust* 251 (1977); III P. Areeda & D. Turner, *Antitrust Law*, ¶ 736e (1978) ("Refusal to deal for political or social reasons amounts to private imposition of sanctions or disabilities which may well, for constitutional reasons, be beyond even legislative power").

ment, and at least one formal hearing (42 U.S.C. 300n-1 (a) and (& Supp. III) 300n-1(b)).[20] Moreover, any final decision to deny an application is judicially reviewable for arbitrariness, capriciousness, or failure to comply with the law. 42 U.S.C. (Supp. III) 300n-1(b)(12)(E).[21]

Thus, to the extent NHPRDA sanctions decisionmaking by State Agencies that might conflict with antitrust policies, the Act provides procedural safeguards and avenues of review to assure that the required balancing of public interest considerations is effectuated in an open forum in full compliance with statutory standards of fairness. In the present case, Blue Cross allegedly imposed an economic sanction on petitioner without the intermediation of any government body. MAHSA, whose policy Blue Cross purported to promote, lacked such power.[22] Under the statutory scheme, MAHSA could only recommend that a state agency foreclose new entry. Neither the statute,

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[20] The Senate bill contained a provision, not included in the House amendment, requiring hearing procedures to be consistent with State administrative law. The conference committee adopted the Senate version, emphasizing that the hearing must be independent of the State planning agency. H.R. Conf. Rep. No. 93-1640, 93d Cong., 2d Sess. 75 (1974). The conference committee also adopted a House amendment to the Senate bill that required the Secretary to review State Agency activities. *Id.* at 82. Those administrative safeguards were provided to assure that review procedures by HSAs and State Agencies be "equitable to all those affected." H.R. Rep. No. 93-1382, 93d Cong., 2d Sess. 84-85 (1974).

[21] In adding a mechanism for judicial review of final State Agency decisions on certificates of need, Congress also provided that the procedural requirements of Section 300n-1(b) may, as appropriate, apply to other review programs. 42 U.S.C. (Supp. III) 300n-1(b)(12). The House Conference Committee explained that *any* review that would prevent a health care institution from providing a service or impose similar economic disabilities should be subject to these procedural safeguards. H.R. Conf. Rep. No. 96-920, 96th Cong., 1st Sess. 77 (1979).

[22] Indeed, respondents do not even contend that they communicated with MAHSA concerning their denial of participating membership to petitioner National Gerimedical.

nor its legislative history, provides any support for granting private providers like Blue Cross more power than MAHSA possessed. In these circumstances, the court of appeals' decision immunizing exclusionary conduct of the kind alleged in the complaint undercuts, rather than promotes, the manifest purposes of the statute.

C. The Court Of Appeals Erred In Recognizing A Broad Implied Repeal Of The Antitrust Laws In The Face Of Statutory Language Conferring A Narrow And Carefully Circumscribed Antitrust Exemption

The court of appeals also failed to give effect to the well-established rule, frequently enunciated by this Court, that when a federal statute explicitly immunizes specific activities from the antitrust laws, that "show[s] beyond question how far Congress intended that the * * * Act should operate to render the Sherman Act inapplicable. If Congress had desired to grant any further immunity, Congress doubtless would have said so." *United States* v. *Borden Co.*, *supra*, 308 U.S. at 201; *Carnation Co.* v. *Pacific Westbound Conference*, 383 U.S. 213, 216-218 (1966); see also *California* v. *FPC*, 369 U.S. 482, 485 (1962). In such cases, the terms of the express exemption themselves provide additional evidence that application of the antitrust laws to conduct not specifically immunized would not frustrate Congress's regulatory purpose. This rule of construction, while not immutable, places a heavy burden on those who would argue that Congress intended to immunize conduct not encompassed within the express exemption. And the burden is particularly heavy here since NHPRDA not only contains a limited express exemption, but its legislative history indicates that Congress deliberately rejected proposals to grant broader immunity.[23]

As originally enacted in 1974, NHPRDA contained a single provision limiting liability. 42 U.S.C. (& Supp. III) 300*l*-1(b)(4), provided that individual members

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[23] As previously noted, the immunity sought to be implied in this case is not necessary to make the health planning statute work as Congress envisioned. See note 11, *supra*.

or employees of HSAs would not be liable for damages under any federal or state law based on activities authorized under the Act, if performed with due care and without malice.

In 1979 the scope of protection against liability for damages was extended to HSAs themselves and to individual members or employees of SHCCs. 42 U.S.C. (Supp. III) 300*l*-1(b)(4)(A), (B), 300m-3(d).[24] The legislative history indicates that, while the Senate bill would have extended such immunity to private consultants or agents of HSAs and SHCCs as well, the Conference Committee rejected that portion of the amendment. H.R. Conf. Rep. No. 96-420, *supra*, at 66; S. Rep. No. 96-309, 96th Cong., 1st Sess. 67 (1979).[25]

During hearings on the 1979 amendments before the House Health Subcommittee, the American Health Planning Association proposed an amendment that would have extended immunity from damage liability not only to members and employees of HSAs and SHCCs but to "agents who voluntarily follow the recommendation of a [State Agency] or HSA made in conformance with the requirements of this act * * *." *Hearings*, *supra*, at 177, 181, 187-188. The Central Virginia Health Systems

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[24] Damage immunity for HSA members and employees was broadened somewhat as well. The 1974 Act exempted acts performed "within the scope of [their] duty * * * exercised [with] due care * * *." 42 U.S.C. (& Supp. III) 300*l*-1(b)(4). The 1979 amendments exempt acts performed "without gross negligence" "if [the defendant] believed he was acting within the scope of his duty * * *." 42 U.S.C. (Supp. III) 300*l*-1(b)(4)(A)(ii).

[25] In hearings on the 1979 amendments, Hale Champion, Undersecretary of HEW, testified that it was his belief that HSAs are immune from antitrust challenge for decisions made pursuant to their statutory mandate (*e.g.*, recommendations concerning certificates of need). He asserted, however, that if HSAs delegate their decisionmaking authority to private parties (*e.g.*, providers), immunity for decisionmaking is lost. *Hearings*, *supra*, at 161. Congress apparently agreed with this interpretation. For, while it extended immunity to HSAs themselves, it rejected proposals to grant immunity to private parties acting as consultants or agents of the HSAs.

Agency also urged that antitrust immunity be extended to providers who work with planning agencies. *Id.* at 701; see also *id.* at 641 (suggestion of the American Medical Association that "[a] new section * * * be added to exempt actions taken in meeting the requirements of the Act from federal antitrust laws"). Despite these urgings, Congress chose to adopt narrowly drawn exemptions, extending immunity only to HSAs and members and employees of HSAs and SHCCs. The express immunity is, moreover, limited to damage actions; injunctive relief is still available.

Thus, Congress carefully considered the extent to which it intended to bestow immunity. It was aware that health providers and insurance companies like Blue Cross would participate with HSAs and their employees in health planning activities. But it chose not to clothe them with general immunity. In view of the measured provision of immunity to certain persons, the absence of an express exemption for others like Blue Cross may not be attributed to congressional inadvertence.

CONCLUSION

The decision of the court of appeals should be reversed.

Respectfully submitted.

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